First National Conference on Orphans and Other Vulnerable Children

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Full Report

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THE CONFERENCE ORGANISING COMMITTEE

From left**: Esmé Kheibes, Prime Time Media; Dr Lucy Steinitz, CAA; Lavinia Shikongo, UNICEF; Jackson Swartz, Prime Time Media; Magda Oliphant, DDSWS; Francis van Rooi, CAA; Rose de Buysscher, FHI; Emma Tuahepa-Kamapoa, NANASO; Paul Pope, DDSWS; Francina Soul, MWACW; Oletu Nakaambo, MWACW; Petronella Coetzee-Masabane, DDSWS.** (See list of participants for contact details.)

FOREWORD

The future of any family, community and nation, including its cultures and traditions, lies in its children. Due to poverty, abuse, violence, disease and armed conflict, many African countries today have an ever-increasing number of orphans and other vulnerable children (OVC). This phenomenon is no stranger to Namibia, and here, as elsewhere in Africa, the OVC population is growing even faster due to HIV and AIDS.

As Namibia's ministry responsible for health and social services, we have always been aware of the OVC situation and its impact on our country as a whole. The Ministry of Health and Social Services has always provided services to OVC, but at the beginning of 2001 we realised that we had to take a national stand on the OVC situation. I am proud that my ministry – with support from and in close collaboration with UNICEF, Family Health International, the United States Agency for International Development and the Government of Finland – was able to hold the first-ever national conference on OVC in Namibia.

The conference was a great success. All stakeholders participated very conscientiously and committed themselves to the cause at hand. I thank them for this response. To the stakeholders, I reiterate my pronouncement during the proceedings: the conference was just the first step in our task, and now YOU must carry the work forward by means of implementing the strategies and recommendations of the conference. A National Steering Committee on OVC has been established to aid you. The committee is tasked to develop the necessary policies, programmes and services, but relies on YOU to assist in this process and to see to it that these interventions succeed.

This conference report is not for your shelf, but rather you should treat it as your constant companion; as a tool that can assist you in your efforts to help ensure the well-being of our country's future – our children.

Dr Libertina Amathila
Minister of Health and Social Services

ACRONYMS AND ABBREVIATIONS USED IN THIS REPORT

AIDS	Acquired Immune Deficiency Syndrome
CAA	Catholic AIDS Action
CARE	Cooperative for Assistance and Relief Everywhere
CBO	community-based organisation
CBS	Central Bureau of Statistics
CCN	Council of Churches in Namibia
CRC	United Nations Convention on the Rights of the Child
DDSWS	Directorate of Developmental Social Welfare Services
DRC	Democratic Republic of Congo
ECD	Early Childhood Development (Programme)
FHI	Family Health International
FPG	Foster Parent Grant
GIPF	Government Institutions Pension Fund
GRN	Government of the Republic of Namibia
HBC	home-based care
HIV	Human Immunodeficiency Virus
HSSSP2	Health and Social Sector Support Programme – Phase 2 (Government of Finland)
ICD	International Cooperation for Development
IEC	Information, Education and Communication
IGA	international grant agency/ies
MBESC	Ministry of Basic Education, Sport and Culture
MG	Maintenance Grant
MOHSS	Ministry of Health and Social Services
MRLGH	Ministry of Regional and Local Government and Housing
MWACW	Ministry of Women Affairs and Child Welfare
NACOP	National AIDS Coordination Programme (in the MOHSS)
NAMPOL	Namibian Police
NANASO	Namibian National AIDS Service Organisation
NEPRU	Namibian Economic Policy Research Unit
NGO	non-governmental organisation
OVC	orphans and other vulnerable children
PRA	participatory rural assessment
SADC	Southern Africa Development Community
SIAPAC	Social Impact Assessment and Policy Analysis Corporation
SMEs	small and medium enterprises
STDs	sexually transmitted diseases
UNAIDS	United Nations AIDS Programme
UNAM	University of Namibia
UNICEF	United Nations Children's Fund
VCT	voluntary counselling and testing
WCPP	Woman and Child Protection Programme
WCPU	Women and Child Protection Unit
WHO	World Health Organisation
ZAMSIF	Zambia Social Investment Fund

OPENING CEREMONY

Session chairperson: Dr Norbert Forster, Under-Secretary, Ministry of Health and Social Services (MOHSS)

Dr Norbert Forster

The conference opened with a prayer led by Sister Shintango of Catholic AIDS Action (CAA), whereafter the national anthem was sung. Dr Forster then welcomed the participants, and notably the Minister of Health and Social Services, the Deputy Minister of Women Affairs and Child Welfare, Members of Parliament, Regional Governors and Councillors, representatives of national and international development partners, representatives of CAA, and consultants to the MOHSS.

Dr Forster expressed the organisers' pleasure that so many invitees were able to attend, thereby demonstrating their support for dealing with a very important issue facing Namibian society: the rising numbers and special needs of orphans and other vulnerable children (OVC). He noted that this conference was called to bring together representatives of various government ministries, NGOs, churches, civil society and development partners to debate the OVC issue with a view to arriving at recommendations that will flow directly into improved programmes for OVC in Namibia.

After the welcoming address the Windhoek-based choral group Vocal Motion 6 took the floor for the first of several recitals during the conference, whereafter Dr Forster inroduced the first speaker.

Setting the tone ...

Above: Participants (left) and key speakers (right) singing the national anthem.

Left: The much-enjoyed choral group Vocal Motion 6. Some songs the group composed especially for this conference; songs about children, relationships, and people working together and learning from one another to overcome the odds, and songs of praise. Their newly released CD is available from selected music retailers. [See contact details on p.91.]

Statement by Ms Khin-Sandi Lwin,

UNICEF Representative in Namibia and Chairperson of the UN Theme Group on HIV/AIDS

Mr Chairperson, Honourable Minister of Health and Social Services Dr Libertina Amathila, Honourable Deputy Minister of Women Affairs and Child Welfare Ms Marlene Mungunda, Director of Developmental Social Welfare Services Ms Batseba Katjiuongua, National Co-ordinator of Catholic AIDS Action Dr Lucy Steinitz, Honourable Members of Parliament, Honourable Governors, Your Excellencies, Ladies and Gentlemen –

Thank you for giving me the special honour of being the first speaker to set the stage at this important event – representing both UNICEF and the United Nations Theme Group on AIDS. All speakers at all events always start with a statement about the event being important, and we all know that some events are more important than others. This one, as a national conference on orphans and other vulnerable children (OVC), clearly falls into the category of more important!

Minister Amathila, your efforts and foresight and those of your ministry in addressing the rapidly growing problem of OVC in Namibia are commendable. May I congratulate you for organising this conference, with its topics and sessions clearly defined and concentrated on the main issues around OVC care. The success of any conference will depend on the final product. This conference has brought together all the experts and people already working with or having the potential to work with OVC in Namibia, who can help the country define what actions are needed to care for them. The future of each one of these children is in your hands. That is chiefly why this event is very important.

There is actually another important event going on in Namibia at the same time: the National Youth Conference. Since youth are more affected by HIV and AIDS, they need to be actively involved in programmes meant to help them 'take control' and stop themselves from contracting the disease. These two events are also linked in that more and more adolescents are becoming primary caregivers for their younger siblings, therefore they will need to acquire parenting and household management skills.

We are all aware that AIDS is now a critical problem for Namibia, and that Namibia is now classified as one of the world's most affected countries. We are all aware that this deadly disease is striking down Namibian women and men in their most productive years. We are all aware of the increase in AIDS-related deaths, and the consequence that more and more children are becoming orphans.

What we are not sure of at this stage are the exact numbers of OVC in Namibia. The estimates for orphans range from 21 000 to 67 000 in the country right now. There are no estimates for vulnerable children – children who may be neglected or abused because of alcohol abuse or family problems relating to poverty, the low status of women and/or the effects of living with HIV/AIDS. What is agreed is that the numbers will increase dramatically within the next five to ten years, this being another reason why this event at this point in time is so important. We need to quickly put in place a few critical measures.

I wish to briefly outline some critical action areas, drawing from lessons learned in other sub-Saharan African countries where AIDS has wreaked havoc in its path of suffering and death. In doing so I will highlight three areas: (1) policy on OVC; (2) support systems for families and communities; and (3) ensuring access to basic services.

The obvious first step is to establish a clear and holistic national policy on OVC care in Namibia. Although there are various policies that can apply to orphan care in the country, given the growing scale of the problem, we need a specific policy to help fulfil the needs and rights of OVC. By 'holistic' we mean a policy that addresses not just the obvious material or physical needs and rights, but also the

need for building knowledge and skills, and for providing psychosocial care. The policy would have to address issues like eligibility criteria for government assistance, implementation procedures and accountability measures. By 'holistic' we also mean a policy on OVC care that goes hand in hand with efforts to address the whole issue of 'care' for people living with HIV and AIDS. I hope that all of you as participants with rich ground-reality experience will come up with very specific action points for drafting this policy.

In view of the growing numbers and the anticipated scale of the problem, we need to have support systems to help families and communities cope in caring for their orphaned children. We are all painfully aware that the current approaches to orphan care will not be enough. The usual 'welfare' or 'charity' type of assistance is not only inadequate in terms of resources (financial and human), but also in terms of sustainable human development. In other words, not only do we collectively not have enough money to hand out, but handing out money makes people dependent and isn't going to help individuals and families learn to cope and help themselves. What needs to be supported is the transfer of knowledge and skills that will enable them to cope and help themselves.

The capacity of the traditional extended family structure is already straining under the growing burdens of caring for more and more orphans. The studies that UNICEF (Namibia) has supported in the past couple of years have revealed this growing burden. I'm sure that each of you has either directly experienced it or encountered families and/or communities facing this strain. If we allow this first 'front line' of care or 'primary social safety net' to collapse under the strain, the problems will worsen. I don't think I have to spell out the implications of children being left on their own. Problems that are still not very serious in Namibia, for example street children, child labour and school dropout, will become very serious – not only for the children concerned, but in terms of threatening the well-ordered society as we know it today as well as national development.

What support systems and mechanisms can be put in place? People living with HIV and AIDS need help – emotional, spiritual, psychological and material – to prepare for death and to prepare their children for the future. A good first step is to reach agreement on guardianship and inheritance rights before a parent or both parents die. Preparing wills, reducing effects of social stigma and giving psychosocial support are just three of the preparatory steps that need to be supported through community structures like churches and community-based organisations (CBOs), local traditional leaderships and government authorities, and non-governmental services. It is important to make sure that the children themselves are involved in such preparations for guardianship, inheritance and emotional, mental and spiritual release.

The communities are the second line of support for the children concerned and the first line of support for the families. They in turn need help to develop the necessary support structures to cope with orphan care. Those closest to the affected families are in the best position to determine who is most at risk or vulnerable; to discern that a parent is ill and in need of help to prepare for the future; and to enumerate and assess the situation and needs of the family. Local self-help efforts need to be encouraged and supported. Apart from helping to start them up, an important area of support for self-help efforts is that of building the 'know-how' that communities need to avoid creating dependency and to build the capacity of children and families to help themselves. Micro-credit and savings schemes, scholarships, home-based care, counselling and psychosocial support are examples of local initiatives that community structures can take up. Government service extension workers, local authorities and non-governmental organisations (NGOs) will need to establish the necessary mechanisms and develop their own capacities to provide such support to communities.

The third critical area for attention is that of ensuring access to basic services for OVC. Three kinds of services are critical, the first being education.

One of UNICEF's recent studies found that 64% of Namibian households with orphans cannot afford school fees. Denying children the right to basic education will reverse many of the country's hard-won development gains of the past decade. Yes, there is a clear policy on school development fund exemption for those who cannot afford to pay, but for many caregivers, who are often illiterate, too old or too poor to be able to deal with bureaucratic procedures, the procedures for exemption are difficult to pursue. Many school principals profess ignorance of the exemption directive, and as the number of orphans increases, many schools will not be able to afford the school fund exemption without government support. How to increase awareness of this exemption policy, how to simplify the exemption

procedures and how to help communities and schools to maintain quality education that is accessible to all children without stigma and discrimination are some of the challenges that this conference can help to overcome.

Access to preventive and curative health services must also be ensured, with greater outreach to all communities to increase and sustain immunisation and Vitamin A coverage and other forms of preventive care. With the stigma attached to HIV/AIDS, many will not come forward for treatment. The estimates are that at least a third of all children born to HIV-infected mothers will themselves be infected. Until we have policies and mechanisms in place that will prevent such mother-to-child transmission, we have to ensure at the very least that health services are geared up to attend to the increased level of infection and illness among children.

A third critical basic service – one that is currently not provided by any government department – is that of psychosocial support. Churches and community groups can play a crucial role in initiating and providing this kind of support, and it should be linked to the home-based care approaches recently introduced in the country.

Ultimately we need to ensure that OVC care is not only holistic, but that it entails a continuum of services that will meet the varying needs of children. While the best and most suitable continuum of care is within the family circle supported by the community as well as governmental and non-governmental services, it is necessary to ensure that there are backup systems where the family either doesn't exist any longer, or cannot or doesn't want to provide the care required. We also have to ensure that institutional care, while being the last resort, is not only available but that the institutions are adequately staffed and equipped to provide a caring and nurturing environment particularly for HIV-positive orphans and those dying from AIDS.

Dear participants, I know I have painted a rather depressing picture. There are certainly monumental challenges facing all of us who bear the obligation and duty to ensure that all rights and needs of children are fulfilled. Our attention must naturally be focused on those who need us the most: the growing number of OVC in Namibia. In the face of such great challenges, the caring human spirit tends to outshine itself. In the face of great adversity, new strategies to overcome the odds tend to emerge from our innate human capacity for innovation. I see in you that compassion and spirit. Let us apply them now to come up with new ideas and approaches, and also practical ways to make old approaches work better.

I assure you that UNICEF and the UN Theme Group on HIV/AIDS stand ready to support Namibia in stemming the tide of HIV/AIDS as well as in finding ways to increase the level of care needed for those infected and affected by the disease. I wish you good luck in your endeavours, and I thank you.

Session chairperson Dr Forster thanked Ms Lwin for stressing the importance of this conference and identifying actions of critical importance that the participants should bear in mind. Most specifically, he said, they should address the need for a national policy on OVC as one of the main aims of the conference. He then introduced the next speaker.

Statement by Dr Lucy Steinitz

National Co-ordinator of Catholic AIDS Action (CAA)

Honourable Minister of Health and Social Services Dr Libertina Amathila, Honourable Deputy Minister of Women Affairs and Child Welfare Marlene Mungunda, Under-Secretary Dr Norbert Forster, UN Representative Khin-Sandi Lwin, Director of Developmental Social Welfare Services Batseba Katjiuongua and Deputy Director Petronella Coetzee-Masabane, Honourable Members of Parliament, Honourable Governors, representatives of other line ministries, parastatal and NGO representatives, church leaders, trade union representatives, members of the media, volunteers, fellow caregivers and caring souls –

Good morning. Speaking on behalf of CAA, I am grateful to the Ministry of Health and Social Services, to the conference organising committee and to our sponsors for organising this conference, which represents a historic moment and a critical opportunity for our future.

It would be difficult to exaggerate the dimensions of trauma that our country will inevitably face in the next five to ten years in terms of the anticipated rise in the number of orphans and other vulnerable children (OVC). We have been visited by a plague of epic proportions which could destroy the very fabric of our society as we know it today.

Every other problem we currently face in Namibia, for example crime, unemployment and even the abuse of women and children, is dwarfed by comparison. In part this is because an increase in the number of OVC in Namibia, and their overwhelming needs, will almost inevitably add to these ills; there will be even more poverty, more crime, more unemployment, more violence and abuse, more disease and suffering.

I say almost inevitably because we still have the chance to make a difference. Our challenge is to turn this nightmare into a nation-building opportunity. This conference marks a crucial first step in that process.

My own wake-up call came three-and-a- half years ago when I led the research that resulted in the book titled More than the Loss of a Parent: Namibia's First Study of Orphans. The study was commissioned jointly by the Ministry of Health and Social Services (MOHSS) and UNICEF. (Its findings are included in the conference handout titled "For the Love of Children".) I remember the exhaustion of caregivers, their sense of hopelessness about the future and their despair at not being able to afford the school fees which were due the following January. I met children who had left school to take care of their sick and dying parents, and who never returned to school after their parents died. I met children caring for children, occasionally alone but mostly in homes nominally headed by an uncle or a grandparent, though sometimes with ten or fifteen or even more orphans under one roof.

I remember scenes of children grieving, and not knowing where to turn for comfort and support. I remember a grandmother who told about her four-year-old grandson who kept playing with a shoebox in the yard – digging a hole to bury it, then bringing it up again, looking inside to find it empty, then starting the whole ritual over again. I remember their faces, their pleading eyes, and my thought: there but for the grace of God go my children – or me.

Each story of hunger, pain, suffering and loss makes one cry. But I also heard many stories of strength, courage, love and hope; of families doing the best they can; of grandparents and aunts and siblings who will not give up; of neighbours helping neighbours; of a little orphan boy living in a tin shack who walks seven kilometres twice per day to and from school in Katutura, and who says he wants to become a doctor; of a 15-year-old orphan girl who was willing to appear on television to tell the people of Namibia to "Wake up!" so that they would not

have to go through the same loss and bereavement that she had been through since her mother (a single parent) died of AIDS six months before.

Sitting among us today are several of the almost 600 volunteers and staff of CAA. These volunteers – and others across the country – are among our greatest heroes. The care that our volunteers are providing to orphans is a direct outgrowth of the CAA Home Based Family Care Programme, for which they have been trained. At first we thought that an orphan support programme would emerge as a separate unit or speciality within our organisation, but our volunteers decided otherwise: they asked to continue visiting the children who they got to know while caring for their ailing parents. The attachment and continuity that they built with these children constitute an important foundation for the future: these volunteers are already known and trusted, with the result that the children as well as their adult caregivers are likely to turn to them for advice, support and referral. In fact, in more than a few cases volunteers also ended up taking children into their own homes, at least on a temporary basis.

About two years ago our volunteers began registering needy orphans in the villages and neighbourhoods in which CAA works, and to date more than 4 000 children have been registered. In addition, to set our framework and some guidelines, CAA developed an Orphan Care Policy two years ago (which is also included in the conference handout package).

Twice a year we offer holiday packages to as many needy orphans as possible. At Christmas time our gifts consist mostly of school supplies, and now – still in honour of Easter – we are distributing 2 000 vouchers for winter pullovers. Last year it was blankets; each year, we hope, it will be something else. CAA also has a small emergency fund from which we distribute the equivalent of a one- month state foster-care grant, with either our own workers or those of the MOHSS doing the initial screening. Since the inception of this fund three years ago, 565 orphans have been helped. We are concerned, however, that the demand for emergency funds will soon outstrip our resources – drawn largely from private donors overseas.

Our Bernhard Nordkamp Centre in Katutura runs a soup kitchen as well as an orphan tutoring and support programme, with about 200 children receiving help on a regular basis. Last year, with assistance from Family Health International (FHI), CAA helped 99 of these children – those considered to be at risk of not attending school – with school uniforms and fees, which opened up places for them in the local school system: prior to this support, in most cases the school principals had stated that their school was completely full. CAA hopes to expand this programme – with some variations – into "the 4 'O' Regions" in 2002, and then into the Erongo Region, focusing mainly on Karibib and Usakos.

CAA is currently developing a training curriculum covering psychosocial issues affecting OVC, meaning issues relating to normal childhood development, loss and bereavement, children's rights and what can be done to meet the emotional and spiritual needs of OVC, which are so often neglected. We plan to begin psychosocial training in 2002, and to make the child-focused training curriculum available to any interested party – with an accompanying Training of Trainers Programme curriculum.

That said, we realise that we are only just beginning to scratch the surface of caring for OVC, and we know that we do not have all the answers to the question of what still has to be done. Far from it. We only know that none of us can meet this prodigious challenge alone. We believe that each of us here has a role to play, but that the solutions must stem from the community base and work their way up. We know that we must work together to empower OVC and their caregivers, and we also know that poverty is nearly always a barrier to the solutions found.

We believe that every child is sacred, divine, made in the image of God, and that the involvement of religious organisations is key to the challenge of rearing the next generation. Churches are ubiquitous; they are found in every village and neighbourhood in Namibia. They are motivated by compassion and visions of hope, and most often they have both the organisational infrastructure and the leadership to fight this 'war' for the protection and future of our OVC.

We are, in the main, a nation of caring and God-fearing people. We must endeavour to remember that the children on whose behalf we shall be formulating recommendations over the next three days are our children, God's children, and our country's future. We of CAA feel very encouraged to see you all gathered here with the same purpose in mind, and we feel honoured to be your partners. We believe that by working in partnership across our great nation, in every community we can engender enthusiasm for taking up the highest of all human callings: valuing and caring for orphans and other vulnerable children.

Dr Forster thanked Dr Steinitz for her message of hope. He recalled the inscription in one of the works of the late Namibian artist John Muafangejo: "Hope and optimism, in spite of the present difficulties." He then introduced the next speaker.

Statement by Ms Batseba Katjiuongua,

Director of Developmental Social Welfare Services (DDSWS) in the Ministry of Health and Social Services (MOHSS)

Mr Chairperson, Honourable Minister Amathila, Honourable Deputy Minister Mungunda, Honourable Members of Parliament, Honourable Governors, UN Representatives, distinguished participants, ladies and gentlemen –

Welcome to the First National Conference on Orphans and Other Vulnerable Children.

I would like to give you some background on the work of the DDSWS and the reasons for holding this conference.

As you may know, the DDSWS is legally charged by the Government of Namibia to ensure the legal care and protection of all children. Each social work office resorting under the DDSWS is staffed by social workers who provide statutory services to children and their families. These services include: foster care; adoption; places of safety; institutional care; and diversion programmes.

To complement these statutory services, and leading from the 1990 World Summit Plan of Action for Children, the DDSWS embarked on a plan of action together with its partners, which developed into the Mobilisation for Children's and Women's Rights Programme launched in 1991. This programme contributes to the realisation of the rights expressed in the UN Convention on the Rights of the Child and the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Within the broad frameworks of these two conventions, the Mobilisation for Children's and Women's Rights Programme directs support towards priority issues that were established in Namibia's First National Development Plan, and which are highlighted in Namibia's National Programme of Action for Children. The Mobilisation for Children's and Women's Rights Programme is also in line with programmes that were developed after the World Summits on the Environment, Social Development and Population, and the Global Conferences on Nutrition and Women.

The primary focus of this programme is the ongoing development of capacity within government bodies and their partnering civil organisations to: (a) advocate for increased attention to all the rights expressed in the two conventions; and (b) plan and implement effective protection and prevention services, and empower men, women and children to practise positive behaviours and to make full use of the protection and care services available to them.

This programme has had and continues to have a major impact on the daily lives of children, women and families. For one thing, it has enabled government departments, NGOs and civil society institutions to make advances in providing appropriate services to meet the needs of children, women and families. The achievements of the programme to date can be summarised as follows:

- It has secured a commitment from the Government, the private sector and other social sector partners to provide resources for the

sub-programme called the Women and Child Protection Programme (WCPP).

- Since the WCPP's inception in July 1993 there has been a continuous increase in the number of Women and Child Protection Units in the country, of which there are now nine, covering most regions.
- A resource book on services available to children in need has been compiled.
- Data has been collected on the extent of child labour in the country.
- A number of training courses on the early detection of disabilities have been run.
- More and more 'street children' are being reintegrated into families and mainstream society.
- Improved partnerships are resulting in the identification and placement of children orphaned by HIV/AIDS and other factors.
- Estate allowances are more accessible today due to good partnerships with the law courts.
- A drop-in centre for children on the streets has been established in Rundu.
- A night shelter for children on the streets or children in need has been established in Windhoek.
- An After School Centre has been established in Windhoek, which serves mainly children from disadvantaged families.

Considering all these successes, you may be asking yourself whether there is really a need for this conference, the answer being simply YES! This gathering has been called because even with all our joint programmes, Namibia is facing a crisis in respect of its orphans and other vulnerable children (OVC), which must be tackled with extreme urgency, but it is so large in scale and the challenges it poses are so diverse and widespread that no single body has the resources to respond unilaterally and effectively.

The main cause of this crisis is the impact of HIV/AIDS. Significant social, economic, demographic and other impacts of AIDS are emerging rapidly in Namibia, and failure to address these effectively will undermine development and possibly social stability. These impacts also pose a strong potential for an ever-growing number of inadequately nurtured, undernourished, under-socialised, undereducated, disaffected young people. The DDSWS cannot tackle this crisis alone; we need your support and assistance. Broad collaboration among a wide range of government, NGO, church, international and civil society actors is essential for defining the problems on the ground and addressing them in ways that will really make a difference to the lives of OVC and their families.

So now you know why you are here. What we hope to see come out of this conference are recommendations and specific strategies that can reach all of our 'hard-to-reach' rural communities and marginalised communities, and strengthen community ties making better use of extension workers and ensuring a more equitable utilisation of the resources at our disposal. We also hope to see a multi-sectoral forum established to coordinate and monitor the provision of services to OVC, coupled with the development and implementation of life skills and income-generating programmes for OVC and their caregivers.

I look forward to our continued work together and to the improvement of services to our OVC. Thank you.

A recital by Vocal Motion 6 preceded the opening address delivered by the Minister of Health and Social Services.

Opening Address by Dr Libertina Amathila,

Minister of Health and Social Services

Mr Chairperson, Honourable Deputy Minister Mungunda (the only parliamentarian I see here besides myself), Honourable Governors, the Representatives of UNICEF and UNAIDS, the advisors and facilitators from Zambia and Washington, all other distinguished guests (you are too many to mention by name), media representatives (thank you for covering this very important conference), Vocal Motion 6 (thank you very much for being here), ladies and gentlemen –

I consider it a great honour to have been asked to open Namibia's First National Conference on Orphans and Other Vulnerable Children. I also feel very sad that we need to hold such a conference in Namibia, but Namibia, like all countries, has its share of orphans and other vulnerable children (OVC), and in the past, like other African countries, Namibia was always able to support them through extended family networks, social safety nets and programmes specifically designed to support them. With the scourge of AIDS, however, we find ourselves fighting a battle that we cannot win without mobilising all the resources available to us.

Owing to our President, the Government of Namibia has always regarded children as the most important members of the Namibian public, so we take their needs very seriously. At independence [in 1990] we had a problem with street children, which we dealt with fast and quite effectively; we returned most of them to school, and today some of them are university graduates. So that problem was not insurmountable, and neither is our problem with OVC. We will deal with this problem, very effectively, and I am convinced that we will turn the tables within the next five years. So let us not despair; let us just work.

Tomorrow I will launch the next of the sentinal[1] surveys on HIV/AIDS that we conduct every two years. These have shown a slight improvement here, more despair there, but on the whole they have shown that for young people the situation has been stable for the last four years. This means that there is light at the end of the tunnel – and a discussion I heard yesterday at the National Youth Conference supports this view: there is light because we are now attacking the issue from all sides of society; gone are the days when only the Minister of Health and Social Services was talking and shouting about AIDS, and being asked, "What are you doing about the people dying?" Now everybody is involved, and our surveys show that the levels of knowledge on HIV/AIDS are almost 100% in Namibia.

I am glad that our regional governors are here, because we have decentralised services to get them closer to the people, and I must ask the governors to tell their communities to take questions about services straight to their constituency councillors. These councillors should be 'first aid', so to speak, for people needing to know, for example, "Where can a woman looking after orphans go for help?" The councillors should provide guidance like this, and if they do not know how to help they should consult the relevant health or welfare office. I think the governors should now call meetings to ask their councillors to take care of their constitutencies in this way.

Our Ministry will very soon be launching a programme that will support this guidance, and any programme for OVC. Everything is prepared, the budget has been approved, three pilot studies have been conducted – in Ohangwena, Oshana and Caprivi – and the people to do the work are in place. These are young people who are well known to their communities. They will go from homestead to homestead – each covering three or four homesteads depending on the size of the area – from door to door, to see the families and get to know them and

[1] The word 'sentinel' is defined in the Concise Oxford Dictionary as "a thing that acts as an indicator of the presence of disease".

who is who and what is happening to them.

This will not assist us only with HIV/AIDS, but also with the current malaria epidemic, which is due to the recent heavy rains, and which is very very serious; many people have died. In the Oshana, Omusati, Oshikoto and Ohangwena Regions in northern Namibia we have had to mobilise staff; my entire team is presently up there dealing with malaria – my Permanent Secretary, my Deputy Minister ... I am literally alone in the office. Malaria too will leave us with orphans, not just AIDS, so we have to broaden our view. I believe that in the next five years we will see an improvement – a great one. Today we have started mobilising our resources, and in five years from now there should be no need for any of our kids to be heading a household and caring for siblings.

AIDS is causing unprecedented threats to the well-being and safety of children. A child's vulnerability begins to increase long before a parent dies. Some common impacts of HIV/AIDS are food insecurity, reduced access to health services, deteriorating housing and material conditions, pressure to drop out of school ... ever-deepening poverty.

The death of a parent brings additional problems. For example, funeral costs consume more resources, and afterwards, the widows and their children may be left destitute if relatives claim the property of the deceased but ignore their traditional responsibility of caring for children left behind. The practice in African cultures of a man's family claiming all his property when he dies because they helped him pay the bride price so he could marry, can leave his survivors without any means to support themselves. Today we also see family members caring for the children of deceased relatives for just as long as the insurance policy lasts; later you find that the child is not going to school, the family has no funds ... many families misuse their pension money ... . Of course in many African societies we still have strong extended family support, but I think this has become more materialistic and less a matter of taking pride in educating and caring well for the child of a relative.

After both parents die, siblings are often divided among several households within the extended family, which compounds their grief and leaves them in emotional distress for a long time. Orphaned children may be treated as second-class members of their new household and be expected to do more work than the other children. The stigma associated with AIDS, school dropout as a result and orphans working on the street all serve to reduce social support and intensify psychosocial distress. I think that through our house-to-house survey teams we will find out what is happening to orphans on a daily basis.

The identification and support of OVC are paramount, and it is our main aim to ensure that children remain in a family setting. What our ministry does not want to do is create more facilities for institutional care. Namibia is a land of families and we want to build on that strength, not destroy it. When I returned to Namibia in 1989 I was shocked to find our old people living in homes. While living in Europe I had felt proud that we Africans do not put our old people in homes. But now we do, or otherwise we drop our children with grandparents who have a monthly pension –this makes them very popular – which they are expected to use to buy the children school uniforms and so on. We have a fund to cover grants to foster parents, which we will now be extending to grandparents who are caring for orphans. So this will be another safety net for vulnerable children in Namibia.

Our main aim is to empower communities to support and care for their own. We also want to build on our successes in home-based care and support, and learn from our neighbours how OVC are being cared for and supported by the whole community as well as social and medical services.

Before I go on to talk about the work of the Directorate of Developmental Social Welfare Services (DDSWS) in the Ministry of Health and Social Services (MOHSS), I would like to note that the DDSWS staff are the people to thank for this conference. I am just a minister there and I was asked to open the conference, but they organised everything, and I ask them all to rise so we can see who they are and applaud them. I thank them for inviting me.

The Government of Namibia has given the Directorate of Developmental Social Welfare Services the legal responsibility to protect and care for OVC. Through its coordination and facilitation of the Mobilisation for Women's and Children's Rights Programme – also known as the Family Life Empowerment Programme (FLEP) – the DDSWS has achieved great successes, but it could not have done so without its working partnerships with other ministries, NGOs and donor agencies. The Government and UNICEF recently reached agreement on a new programme of cooperation for 2002-2005 – thank you UNICEF! For this programme, in collaboration with our international

partners, UNICEF particularly, and many NGO and civil society representatives, we have set ourselves a number of objectives which we must start working on as from the end of this conference, and at the end of 2005 we will take stock of our situation and determine our next course of action. As in the previous programme, young children, adolescents and vulnerable groups will be the focus of this new programme. Examples of the projects and objectives for OVC are as follows:

A project aimed at decreasing exclusion will give at least 60% of all OVC access to basic education, medical care, counselling and protection from loss of property, and at least 80% of OVC and their caregivers increased knowledge of their rights and what services are available to them. We also want at least 60% of all women and children living with HIV/ AIDS to have access to basic social services, and an 80% increase in knowledge of their rights and the services available to them. It is very important that people know their rights, because they will not access the available services without that knowledge.

A project on communication for improved child and maternal care will aim to reach at least 50% of all parents or guardians of children under 5 years of age, or those expecting children, to give them information on maternal and childcare practices in relation to health, nutrition and the psychosocial development of children. We have to bring this knowledge to their doorsteps. We know that psychosocial support especially is lacking, so we have to put more energy into providing this support, and into counselling services generally. We have to train many many more counsellors – lay counsellors too, because churches, for example, do a lot of counselling and are very involved with the care of OVC. At this point I would like to call on my own Lutheran Church to match the services of the Roman Catholic Church. From some of our churches all one hears today is criticism that TV programmes on AIDS are teaching people to have sex. I think this should stop. We have a problem. We can't sweep it under the carpets of the Safari Hotel. We have to take the cow by the horns ... I say the cow because we have been taking the bull by the horns and we have gone nowhere; the bulls have done nothing. So this time let us take the cow, and after five years you will see success! [This impromptu remark was met with laughter and loud applause.]

A Health System Support Project will aim to develop the planning, coordinating and management skills of health programme managers, which in turn will improve access, coverage, efficiency and quality of services. It will also stop our nurses (particularly the older ones) from harassing young girls about their behaviour when they come for help. Every time I open my mouth I talk about the need to re-train our staff so that they view the problem differently. It is the new millennium after all!

A project for promoting collective childcare will aim to give at least 50% of all OVC access to quality day care, and at least 80% of day-care facilities the means to provide free day care for OVC. It will also entail childcare workers mobilising parents and communities to adopt better childcare practices. I think that parents should help day-care centres rather than see them as places where they can drop off their 'problems' for the day.

Projects like these will:

- increase the capacity of families to care for young children, adolescents and OVC;
- increase the capacity of communities to support young children, adolescents and OVC by way of collective problem-solving, and construct new social relationships and dependencies between children and their adult caregivers;
- build an enabling environment in which it becomes easier for children and families to cope;
- strengthen capacities of essential services; and
- build on the coordination of our multi-sectoral response.

Even with projects like these, however, the MOHSS through the DDSWS and its partners may not be able to handle the crisis we face, which is why we have brought you all together – so you all know that you will have to pitch in and not just leave the problem to the MOHSS and the Government.

This brings me to the role of the private sector, and I would appeal to insurance companies particularly to meet us half way in terms of policies for people living with HIV/AIDS. When I wanted to bring in a notification to reduce the HIV/AIDS stigma by breaking silence, people feared that relatives of those who die of AIDS would not be paid out, and indeed I have been told of people who lost their policy because they died of AIDS. This

is a serious problem, and I have taken it up with a couple of insurance companies, but to no avail. Lest I be taken to court, I am not saying that all insurance companies meddle with the policies of people with HIV/AIDS, but I am reporting to you what our communities say. Insurance companies can help to reduce the HIV/AIDS stigma. If we do not get rid of the stigma, our efforts for OVC will not succeed.

I have mentioned our aim of increasing community support to OVC. In our villages, in the past and today, if someone dies and the family cannot afford to buy a coffin, everyone brings a piece of wood to make one. This kind of traditional community support is still a reality, and we need to build on it by giving some kind of support to the communities. We should not entertain any ideas about building institutions, but rather, we must encourage and offer families support to foster OVC. It will be expensive, since we are looking at grants of about N$200 per child, but we have to do something. We can start by working together to come up with a proper policy that will make people willing to take in OVC. Remember that we are not focusing only on orphans due to AIDS, but also on those orphaned by malaria, road accidents and so on. We have a great many orphans to support.

As with the Second National Strategic Plan on HIV/AIDS launched by our President, which involves every sector, we too are setting this challenge to everyone present. We believe that we are all responsible for protecting and caring for our OVC. We ask you to work over these three days towards meeting this challenge. To aid you in your task we have established very clear objectives, as follows:

- To prioritise issues of concern for OVC.
- To develop specific strategies for the protection of the rights of OVC.
- To develop terms of reference for all the stakeholders.
- To mobilise all sectors of our community.

Based on these objectives we have set you working sessions in which you will debate all the issues, make recommendations and come up with strategies to deal with the challenge. By itself no single intervention will make a substantial impact on the full range of social, health, economic and psychosocial problems facing OVC; the problems are too many and too varied. So, a planned and coordinated set of policy, social mobilisation and programmatic interventions by actors in the public sector and civil society is needed; it is the only way forward. Please do not give us complicated and unsustainable recommendations; they must be practical and sustainable.

The picture may look disastrous today, but other countries whose situation was much worse than ours, like Uganda and Senegal, have managed to greatly reduce vulnerability to HIV/AIDS. I am convinced that in five years we will see very positive changes. We started early – already at independence we started talking about AIDS – and as I mentioned, HIV status among our youth has stabilised over the last four years, so I think they are listening to us. I will call on our university students particularly to take up the fight against AIDS very very seriously. Like in Uganda and other countries, young people should take the lead. I might note that a study conducted among our mine-working population found only 7% to be infected with HIV. Considering that in most African countries the mining sector has been found to have the highest rate of HIV infection, I was very encouraged by this relatively low rate among Namibian miners.

On the matter of infection rates, there has been a misunderstanding in Namibia which we have to correct: you have heard that 20% of Namibians are infected, but this is in fact the rate among pregnant women and not the general population. The infection rate among the general population is only 7-8%. But on hearing that, don't go and lie down thinking that you will wait until 20% of Namibians have HIV! The rate in Senegal is already down to about 2%. One of our focal groups in this regard should be truck drivers. In South Africa a study found about 56% of all truck drivers to have HIV. I told the councillors in Gobabis recently to put the new truck port far far out of town, and I will hold the Omaheke councillors and the Gobabis Municipality responsible if the figures for Gobabis don't change by next year! All over SADC this is a very serious problem.

I would like to note my support for the Prime Minister's statement yesterday about traditional healers – who are not 'healers' if they tell people

to sleep with a virgin to cure their HIV/AIDS. He said, "[This practice] must be condemned with the contempt it deserves." Apart from anything else, these 'healers' are adding to the extent of child rape in our country.

I will continue dealing with the issue of notification for HIV/AIDS. Notification will be very important when we start our programme to curb mother-to-child transmission of HIV: communities must not harass mothers about breast-feeding; they must start supporting and stop judging other people. With notification we cannot be taken to court for exposing HIV status or breaking confidentiality when, for example, we discover that a person has been willfully infecting others. Notification will also make it easier for families to cope with the disease.

Though I do not like to quote other authors, I have been given a quote by James Grant of UNICEF which I would like to share with you to end my address:

> Childhood is a period when minds and bodies, values and personalities are being formed, and during which even temporary deprivation is capable of inflicting life-long damage and distortion of human development.

We are doing well in reducing our infant mortality, but we have a long way to go to ensure that no Namibian child is deprived of the chance to develop fully.

Ladies and gentlemen, this very important conference is now officially open, and I wish you very fruitful deliberations. I will try to join you again during the next three days. Thank you.

In thanking Minister Amathila, Dr Forster noted that the information she had provided on the community perspective and on the specific objectives of Namibia's HIV/AIDS programmes would set the scene for much of the work to be done at the conference, particularly by the working groups tasked to devise strategies and specific recommendations.

Vocal Motion 6 gave a final performance, this time noting that their newly recorded CD would be available in two weeks' time.

Next on the agenda was the screening of a video titled Save Our Children – Save Our Future, produced by Prime Time Media in Windhoek with funding from the Government of Finland. The video was produced specifically to stimulate the conference discussions, and had already been screened on NBC TV to inform the public on the OVC issue. It features one of the few Namibians who have had the courage to openly discuss their HIV-positive status and the future of her two children. The other interviewees are Minister of Health and Social Services Dr Libertina Amathila, Deputy Director of Developmental Social Welfare Services Ms Petronella Coetzee-Masabane, UNICEF Representative Ms Khin-Sandi Lwin, CAA National Co-ordinator Dr Lucy Steinitz and Ms Agnes Tom of CAA's Bernhard Nordkamp Centre in Katutura. Copies of the video are available from the DDSWS.

Vote of thanks from Ms Petronella Coetzee-Masabane,

Deputy Director of Developmental Social Welfare Services (DDSWS)

Mr Chairperson, Honourable Minister Amathila, Honourable Deputy Minister Mungunda, the UNICEF Representative, our Director Ms Katjiuongua, all other dignitaries present here, dear participants who have taken the time to be here –

Some three months ago, a group of farmers donated 11 Damara sheep to the President, who in turn decided to donate them to our Ministry in support of orphans, the idea being that we would start a breeding project with this apparently very high-quality stock. In our Minister's absence our Deputy Minister went to receive the sheep. At the end of the handing-over ceremony, the President called me over and said, "I just came from the hospital where I saw a lot of sick and miserable children. What are you doing about the suffering children?" As I began to reply he said, "No no no, whatever you are doing, do more!" In all my interactions with the President over the years, this was the first in which he did not smile, so I took his words very very seriously.

Immediately upon returning to the Ministry we started a consultation process to take stock of what we were doing for children and what was still lacking in our services. We consulted very widely – with all our own senior staff and social workers, officials in other ministries, UNICEF, CAA, NANASO and too many others to mention here. We came up with some ideas, but we didn't have the funds to carry them through.

Then one day I was called to meet with the new FHI representative in Namibia and USAID representatives, who wanted to know about our directorate's work. In informing them I also noted our wonderful plans for OVC, and of the difficulties that were holding us back. They said that we should talk further because they may be able to help us. It is due to their support and hard work that we are here, and I would like to thank them all very much.

Comrade Minister Amathila, we didn't invite you here just because you are the Minister of Health and Social Services or as a sign of respect or courtesy; we invited you because we know – since you have proved it to us time and again – that your commitment to the plight of our children is absolute, and because we know that under your strong leadership and expert guidance, we will make a success of this conference. We would welcome any input from you into our discussions here if you are indeed able to join us again during the next three days.

> The representatives of the main sponsors, namely FHI, USAID, UNICEF and HSSSP2 through the Government of Finland, were asked to rise, and thereafter the members of the conference organising committee.

I would also like to thank Dr Forster, our Under-Secretary, who is newly appointed but who is already well known to many of us as a very committed cadre in the struggle for the health and social well-being of all Namibians.

I thank also our regional governors and all the other participants from the regions who have travelled a very long way to be here. We know that many of you are in demand at other conferences going on now, and we thank you for choosing to attend this one.

The international experts who have come from Zambia and the US, and our ICD volunteer Mr Paul Pope, our Directorate's very competent advisor on HIV/AIDS, thank you all for availing your expertise. Thanks also to SIAPAC for your expertise in conducting our national survey on orphans. I wish to express my gratitude also to our Director for her

unwavering support and encouragement.

I thank Prime Time Media, contracted by the DDSWS to help organise the conference. Apart from the video that you have already viewed, Prime Time Media has been commissioned to produce a video on the conference itself. This should include interviews with delegates from the regions regarding what is happening in the regions, as well as coverage of the conference outcome. So at the end of the day we will have two videos on OVC in Namibia – in fact the first videos in Namibia's history to document this topic – and we are very grateful to the Government of Finland for the generous assistance enabling us to cover the production costs.

There are many other people to thank, but I cannot possibly mention them all by name. In conclusion I want to thank Vocal Motion 6 for the beautiful songs we have heard today. Like their song "Move over ...", I just want to say, "Move over Boyz 2 Men, here come the Namibians!"

I hope our deliberations here will be very fruitful. We will not talk only about the bread-and-butter issues affecting OVC, but also we will talk about the psychosocial support so desperately needed. I thank you all.

Cameraman Vernon Rassweiler of Prime Time Media filming the proceedings for a video intended to document and publicise this crucial first step in the national response on OVC.

The conference gave these community activists an opportunity to raise funds for people living with HIV/AIDS through sales of handcrafted items like bags and badges.

The following quotation was read in full by UNICEF Representative Ms Khin-Sandi Lwin during her presentation on "Psychosocial Issues Facing OVC" (see next section, Expert Presentations, p.31 – commentary on Slide 3 of the presentation).

> One way to understand how loss affects children is to imagine that each child enters this world with a tiny arm through the handle of a tiny bucket. As children grow larger, so do their buckets. Much of how they react and how they see themselves is determined by what goes into this bucket. If children make secure attachments to other people, positive energy pours into their bucket. As they continue to experience good nurturing and positive interaction, their bucket fills up with good feelings about themselves, which enhances their self-esteem, promotes ample physical and psychological energy, and allows them to give freely of themselves. In time, they dip into their bucket and ladle good feelings into the buckets of those around, only tentatively first and then more freely as they discover that their sharing brings other good feelings. ... Separation and loss interrupt or end the interaction with the person who is gone, lowering the level of the good feelings and energy and challenging the security of children's attachment and their positive self-regard.
>
> Extract from Claudia Jewett, Helping Children to Cope with Separation and Loss, London, 1994, p.153.

EXPERT PRESENTATIONS

Session chairperson: Dr Norbert Forster, Under-Secretary, MOHSS

Notes to the reader

The following transcriptions of the expert presentations combine the content of the slides shown and the presenter's commentary. The rapporteur had intended to document the slides in their original graphic format, but it was agreed that due to space constraints only the wording of each slide should be documented – in a uniform layout style – except in the case of graphs and other graphic depictions, which appear in their original digital format.

To preserve continuity in the arrangement of this report, the presentation on the OVC situation in Zambia, which was given on the second day of the conference rather than in this session, is recorded as the fourth expert presentation.

The salutations and words of thanks expressed at the beginning and end of each presentation will henceforth be excluded from the transcriptions.

Questions from the floor and the responses are recorded after each presentation.

Modelling of the HIV/AIDS Epidemic in Namibia

Dr Fred van der Veen,
FHI Technical Advisor to the National AIDS Coordination Programme (NACOP) of the MOHSS

For the next 20 minutes I will share with you some of the information that was prepared during a consensus-building workshop that the MOHSS organised in September 2000 with technical staff involved in modelling the HIV/AIDS epidemic in Namibia from many sectors and agencies, including the Secretariat of the National Planning Commission (NPC) and the Central Bureau of Statistics (CBS) in the NPC, UNAM, NEPRU, UNAIDS, WHO, the World Bank and Namibia's insurance sector.

The workshop was facilitated by an expert (Ms Foreit) from the Futures Group, this being the organisation that developed the demographic package known as Demproj – which the CBS had already used – as well as an AIDS Impact Module.

A detailed draft report of the workshop – incorporating the modelling tool, the assumptions and the outputs – is currently in circulation and I will therefore not go into technical details. [Note: The launch of the final report was in fact scheduled for the following day.]

SLIDE 1: The purposes of modelling:

- To understand the dynamics of the epidemic.
- To predict the future impact on demographic indicators.
- To use the information for planning.
- To update the model according to new findings.

SLIDE 2: How the epidemic can be modelled:

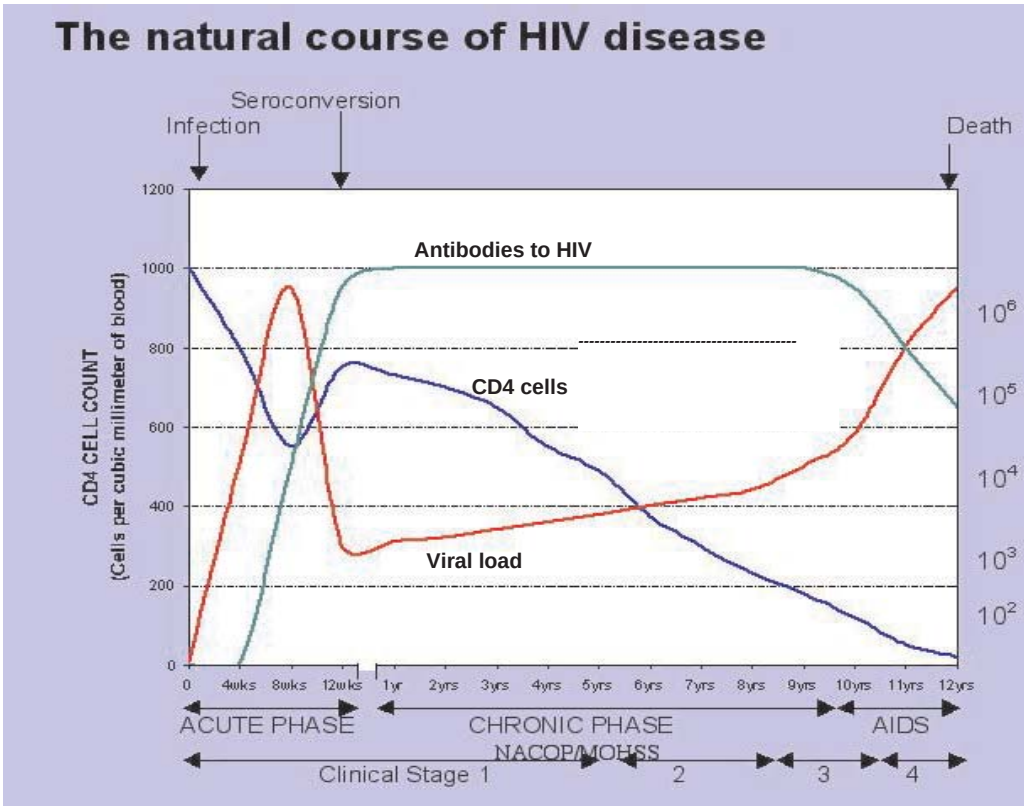
- By understanding the natural course of HIV disease [see Graph 1].
- By understanding basic epidemiological principles.
- By understanding the epidemic's effect.
- By agreeing on data sources and assumptions.
- By using a comprehensive computer programme.
- By verifying, disseminating and discussing the outcome.

Graph 1 shows the average course of HIV infection in all individuals.There is a lot of variation in the way that HIV affects individuals, so it is difficult to predict the course of infection in any individual, but on a large scale, the average course of infection and disease is well understood:

- A short acute phase begins immediately after infection and lasts about 3 months.
- This is followed by a long chronic phase lasting on average 8-10 years, i.e. it may be shorter or much longer depending on various factors, during which people are healthy and usually unaware of their infection.
- In the third phase, infection symptoms related to the weakness of the person's immune system begin.

COMMENTARY: For a good understanding of the AIDS epidemic and its impact, it is very important to know the course of HIV disease. This knowledge is important because there is a long period of asymptomatic infection (or an 'incubation period'). Just after infection (i.e. even within a couple of weeks) one has many viruses [see Viral load line in Graph 1], but the immune system responds to these quickly, and almost

GRAPH 1: The Natural Course of HIV Disease



manages to reduce these to a very low level. At the same time during this initial phase, the CD4 cells – the 'commanders in chief' of our defence system – are being attacked by the viruses, so they are declining very rapidly, but thereafter there is a massive reproduction of the CD4 cells. The antibodies only emerge after a three-month period – sometimes earlier, sometimes later; as I have said, there is a lot of individual variation, and some die of acute infection early, others only have problems midway, and some live happily with very few or no symptoms for 15 years. The natural course of HIV disease will naturally be a lot shorter in a person who develops pneumonia, for example, during the chronic phase (say, after about six years), and who is not given the right treatment for this curable illness. Although Graph 1 derives from industrialised and more wealthy countries where they can measure the parameters routinely, these are the agreed assumptions that we have used for modelling the epidemic in Namibia.

FIGURE. 1: Epidemiology of Infectious Diseases

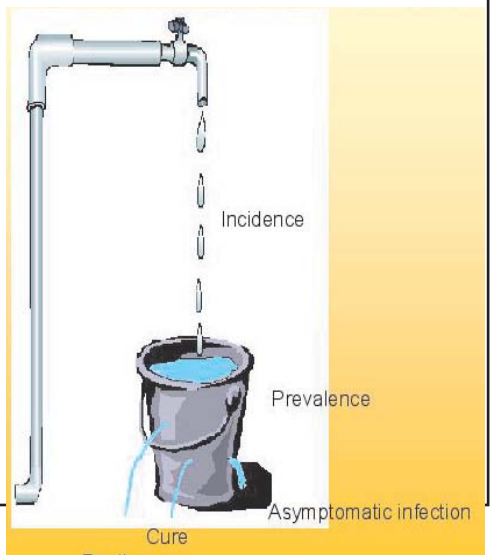
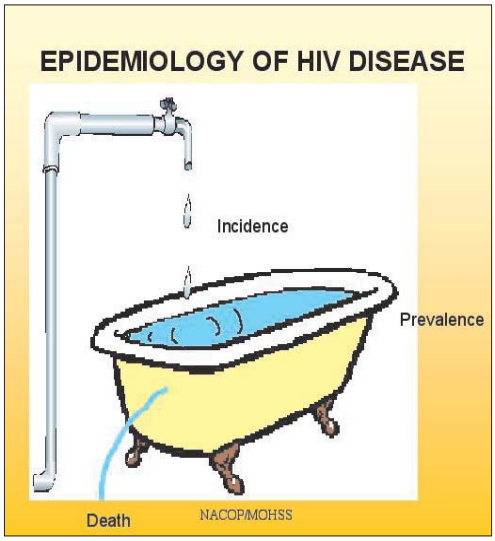


FIGURE 2: Epidemiology of HIV Disease



COMMENTARY: In Figure 1, how widely the tap is open reflects the rate of infection or incidence of new cases, and the fullness of the bucket reflects the prevalence of infection in a society. Figure 1 also shows that some people have an asymptomatic infection, i.e. they may not even know they are infected or they are immune (as is often the case in a flu epidemic); others are cured of their infection and may become immune; and others die of the infection, though for most infections death is a rare outcome.

COMMENTARY: In Figure 2 the rate of new infection is not as high as the rate in Figure 1, but since people infected with HIV are not cured, prevalence remains high and death is the only way out of the bucket. Prevalence remains high also because of the long incubation period.

SLIDE 3: Some characteristics of any epidemic – an S-shaped curve:

- An initial phase with a slow increase in prevalence.
- A phase of exponential growth – doubling every 2 years.
- A levelling off to the plateau phase.

COMMENTARY: The prevalence for most infectious diseases drops almost as fast as it escalated, due to the rapid search for and application of treatments to cure and make people immune. This is not the case with HIV, however.

SLIDE 4: The effect of HIV/AIDS on demographic indicators:

- Increased mortality of adults aged 15-49 years.
- Increased mortality of children under 5 years.
- Reduced fertility of HIV-infected women.

COMMENTARY: We focus mainly on the age group 15-49, but of course in modelling we look at all age groups independently. Most children born with HIV die within the first five years of life, but certainly not all. We use this combined specific effect of HIV/AIDS for modelling the epidemic.

Our demographic indicators are drawn from the NPC/CBS population census data, these being the most reliable data we have for modelling. Until the 2001 population census data become available, we continue to use the NPC/CBS 1991 census data, which incorporate the NPC/CBS projections for population growth without HIV/AIDS. To be able to predict how the population would develop with HIV/AIDS, we have to conduct HIV surveys on pregnant women, i.e. Sentinel Sero Surveys [see commentary on Slides 5 & 6 and Graph 2].

SLIDE 5: HIV Sentinel Sero Surveys:

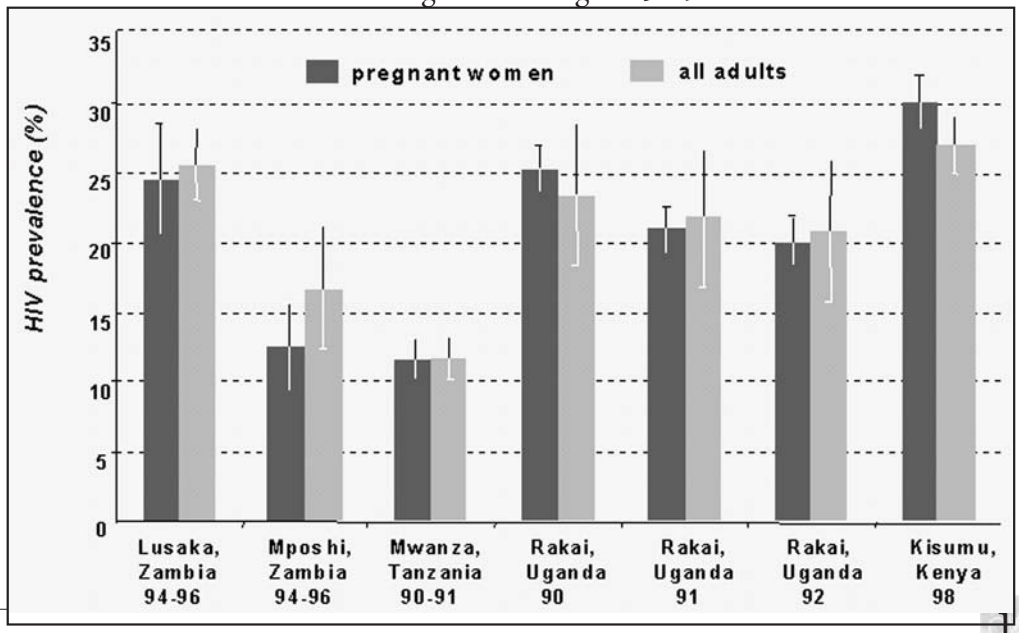
- Pregnant women during first visit.
- Anonymous and unlinked.
- Representative.
- Accessible.
- Constant method over time.
- Proven affordable and sustainable.

SLIDE 6: Validity of HIV Sentinel Sero Survey data:

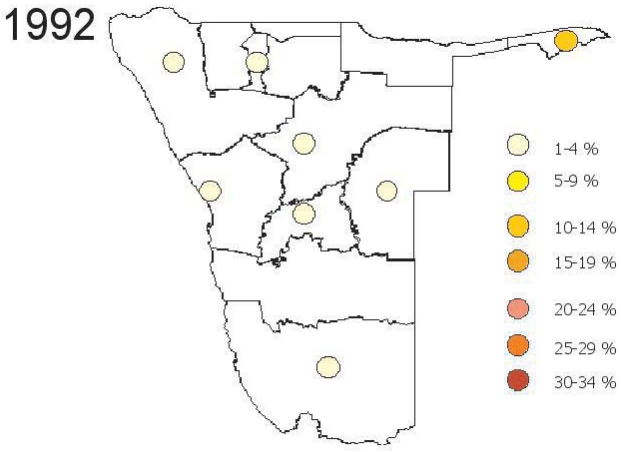
- HIV prevalence in pregnant women.
- Population-based surveys.

COMMENTARY: Because the average course of HIV disease is known, it is possible to predict its impact in terms of illness and death if we know how many people are infected and when they were infected. Most people with HIV do not have symptoms and therefore do not go for HIV testing. To estimate the number of people infected and when they were infected, we need population-based information. It is practically, ethically and financially impossible, however, to carry out large-scale population surveys on HIV infection. Therefore, since the start of the HIV/AIDS epidemic, a surveillance system incorporating regular surveys among pregnant women has been established in most countries, i.e. the HIV Sentinal Sero Surveys. To validate the data from Sero Surveys, some countries (we cannot do this in Namibia as yet) have conducted studies to compare this data with data from general population-based surveys. Graph 2 shows how well the data for pregnant women match the data for the general adult population aged 15-49 years in each country. In some countries the figures for pregnant women are lower, in some they are higher, but overall they are comparable. So the HIV Sentinel Sero Surveys are

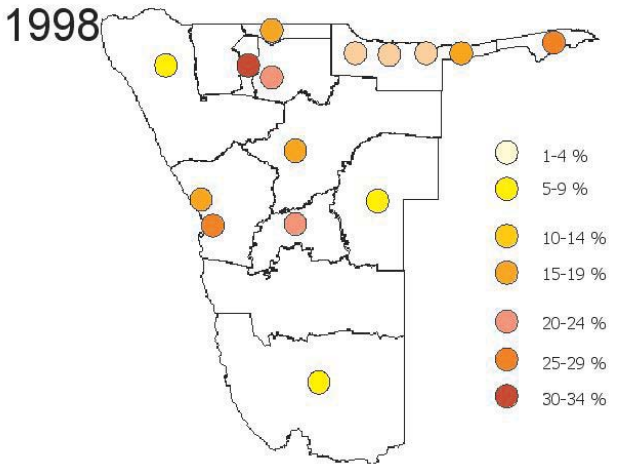
GRAPH 2: HIV prevalence rates among pregnant women and among all adults aged 15-49



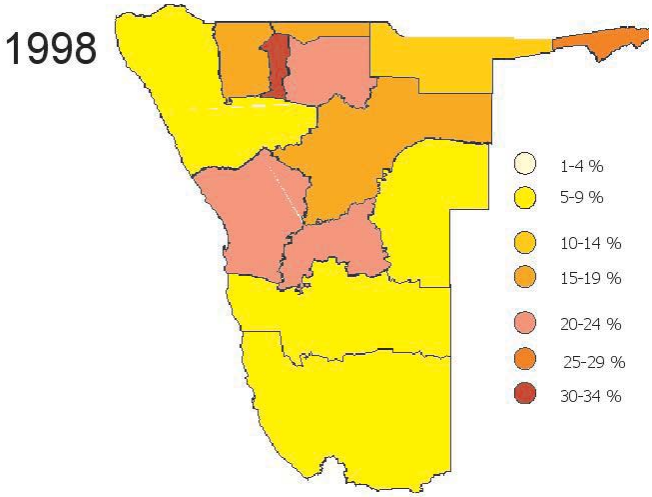
Map 1: 1992



Map 2: 1998



Map 3: 1998



a useful instrument for modelling the HIV/AIDS epidemic.

COMMENTARY: Maps 1, 2 and 3 show the sites (i.e. clinics) of the regional HIV Sentinel Sero Surveys conducted among pregnant women in Namibia during the 1990s, and the rate of infection in each region surveyed.

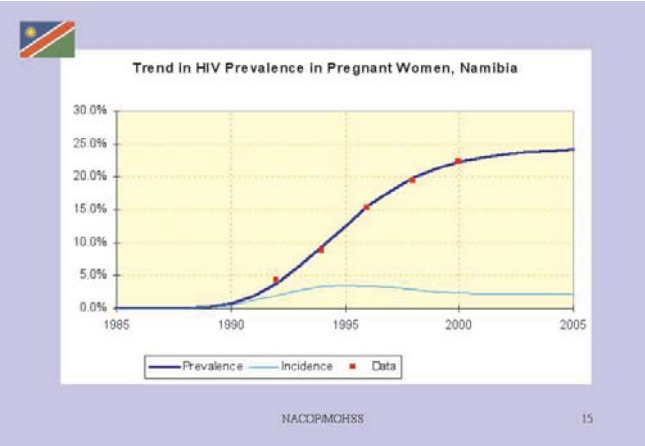
HIV was present all over the country when the first surveys were conducted in 1992 [see Map 1], so the epidemic started well before 1992. But only in Katima Mulilo in the Caprivi Region was HIV prevalence higher than 5%; at 10-14%, Katima's rate was more in sinc with the rates in neighbouring countries.

Map 2 shows that by 1998, nowhere in the country was HIV prevalence among pregnant women lower than in 1992, and everywhere it was higher than 5%. Oshana had the highest rate in 1998 at 30-34%, and Erongo and Caprivi the next highest at 25-29%. Very few regions still had a prevalence of under 10%.

In some regions these surveys have been conducted at more than one site, and there are regions that have not been surveyed yet. With each survey (including the 2000 survey) the number of sites has been increased, so the surveys are becoming more representative. Due to regional discrepancies in site numbers it is necessary to make further assumptions about the distribution of HIV in the country. Further, there are vast regional differences in population density, thus to determine how the epidemic is evolving in Namibia, we have to weigh up these factors and balance out the figures. It is agreed that population growth will be reduced by a combination of these factors: infant and child mortality; mortality of women in the reproductive age group; and reduced fertility of HIV-infected women.

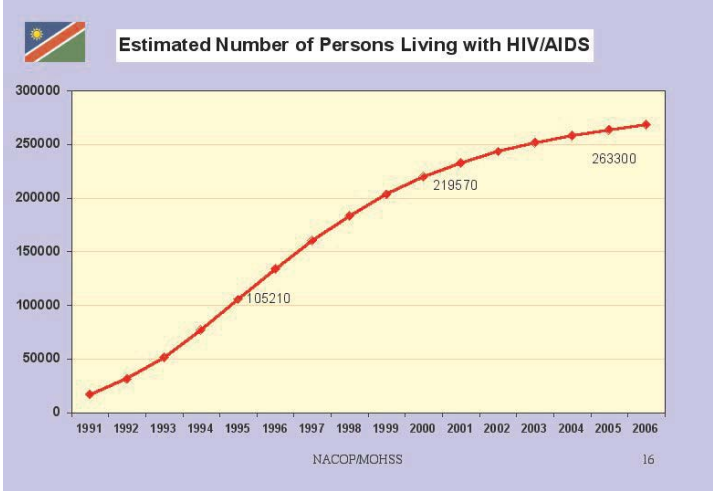
As shown in Map 3, the 1998 findings made it possible to determine regional and national estimates on HIV prevalence among pregnant women, and by deduction, among people in the 15-49 age group. The most densely populated regions are also the most highly infected. This finding has been taken into consideration in calculating national figures for respective years.

GRAPH 3: Trend in HIV Prevalence in Pregnant Women, Namibia



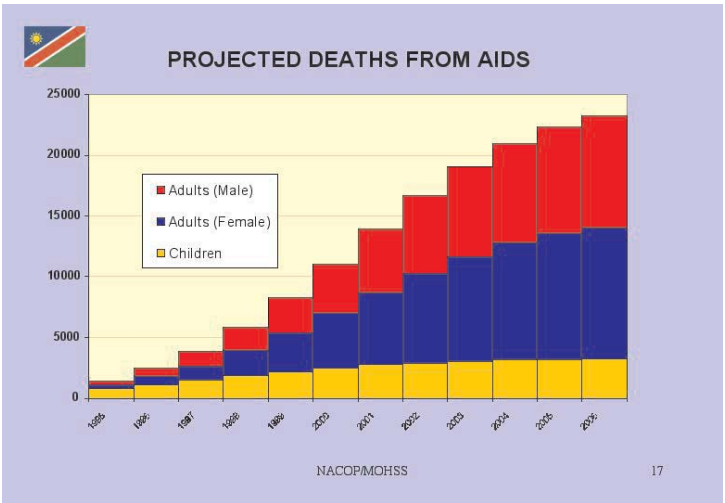
COMMENTARY: Graph 3 shows that the trend among pregnant women in Namibia is closely following the S-shaped curve that is characteristic of all epidemics, and which is used to make further projections. Based on the national data from the HIV/AIDS Sentinel Sero Surveys conducted to date, Graph 3 indicates that among pregnant women the epidemic will stabilise at around 24% by 2005. At that point in time the number of deaths from HIV/AIDS will equal the number of new infections.

GRAPH 4: Estimated Number of Persons Living with HIV/AIDS, Namibia



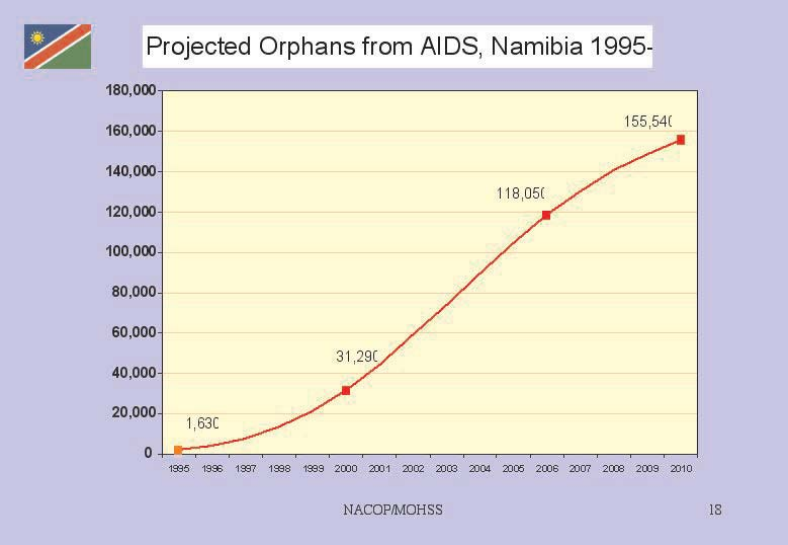
COMMENTARY: Once there is agreement on the sero survey results, the computer can be used to model the epidemic using these results together with the 1991 census data. The first calculated modelling output in which we are interested is the total number of people in Namibia living with HIV/AIDS, as reflected in Graph 4, which shows that the number of adults and children living with HIV/AIDS has increased rapidly since 1991; it reached the 100 000 mark in about 1995 and the 200 000 mark in 1999, and it will slowly increase to around 260 000 by 2006.

GRAPH 5: Projected Deaths from AIDS



COMMENTARY: Taking into account the natural course of HIV disease and all the data gathered to date, we can predict the trend in the number of deaths of adults and children from AIDS, as reflected in Graph 5. Due to the long incubation period in adults, the number of adult deaths will increase drastically in the coming years. The impact on infant and child mortality will stabilise earlier since the incubation time is usually shorter in children.

GRAPH 6: Projected Orphans from AIDS in Namibia, 1995-2010



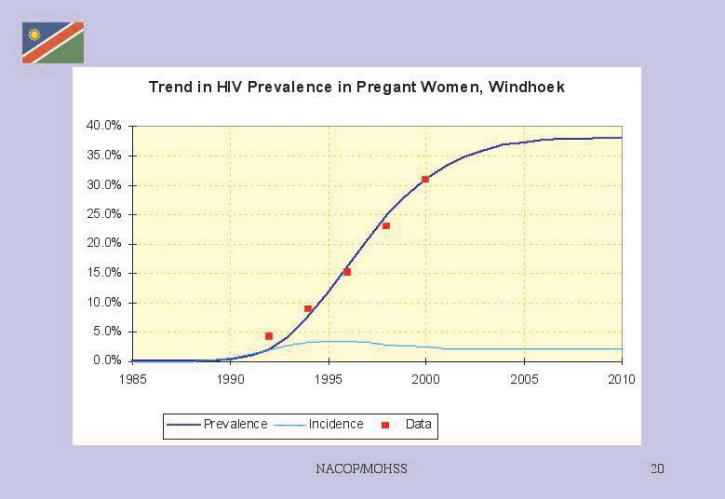
COMMENTARY: Increased mortality of adults due to HIV/AIDS has a sustained impact on the number of children orphaned by the epidemic, and as Graph 6 reflects, the number of AIDS orphans in Namibia is expected to triple over the next five years – from the current 31 000 to about 118 000 in 2006, and to about five times the current number by 2010.

SLIDE 7: Limitations of the current model:

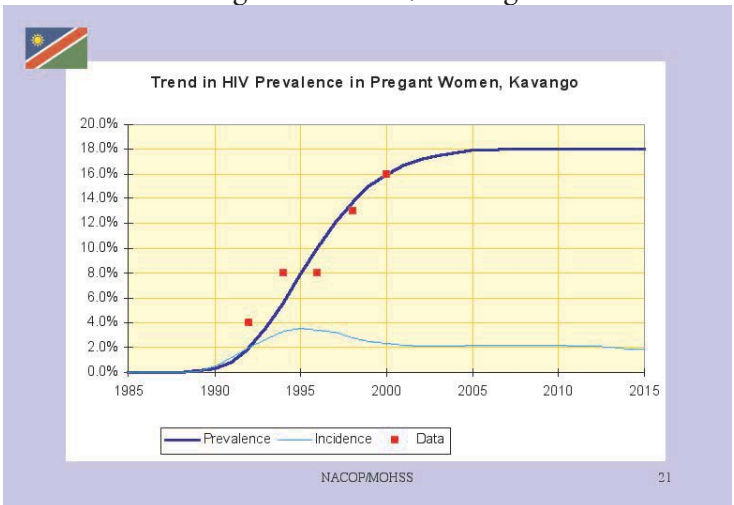
- The international definition of orphans is children aged 15 years and under, whereas the Namibian definition is children under 18 years.
- The model only calculates HIV/AIDS-related orphans.
- Only national estimates are available, i.e. there are no regional estimates.
- There is no data available on migration of orphans.

COMMENTARY: Graphs 7 and 8 show the regional estimates of the HIV prevalence trend among pregnant women in Windhoek in the Khomas Region and in the Kavango Region. In Windhoek prevalence is likely to rise to nearly 40% by 2010, while in the Kavango it will rise to around 18% in 2010. We can see from these graphs that the regional variations are considerable.

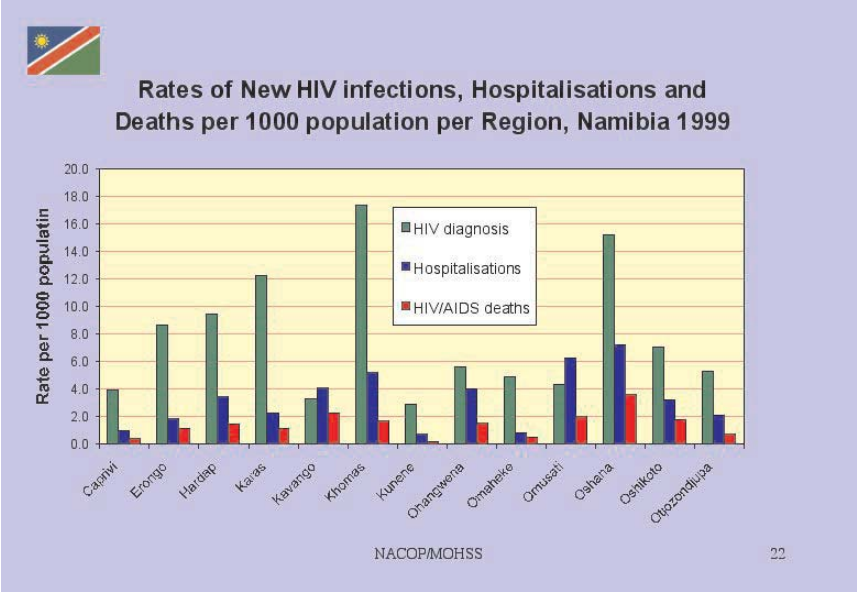
GRAPH 7: Trend in HIV Prevalence in Pregnant Women, Windhoek



GRAPH 8: Trend in HIV Prevalence in Pregnant Women, Kavango

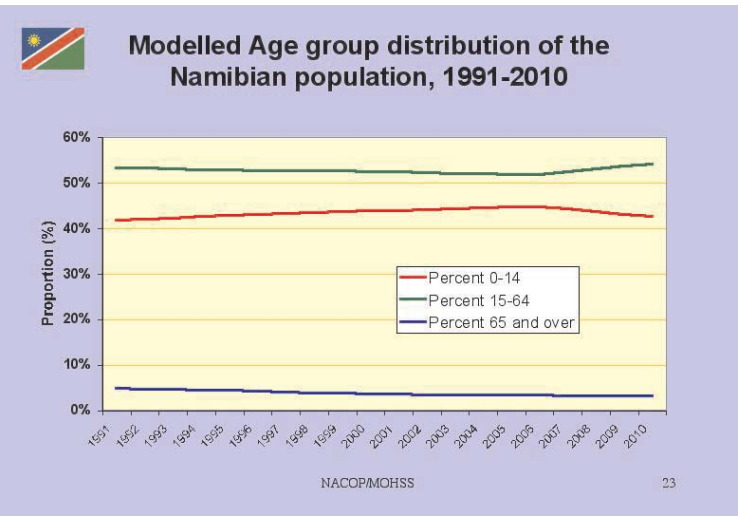


GRAPH 9: Rates of New HIV Infections, Hospitalisations and Deaths per 1 000 People per Region, Namibia, 1999



COMMENTARY: Graph 9 has nothing to do with the modelling of the epidemic, but just gives an idea of the numbers of new infections, hospitalisations and deaths from HIV/AIDS reported for each region during 1999. As we can see, though Windhoek and Oshana had the highest number of new infections, it did not automatically follow that they also had the highest number of hospitalisations and deaths from HIV/AIDS. In the Kavango and Omusati Regions, for instance, fewer people were diagnosed with HIV than the number actually hospitalised due to HIV/AIDS. This means that the modelling on its own does not tell us precisely where or what the impact of the epidemic will be in reality.

GRAPH 10: Modelled Age Group Distribution of the Namibian Population, 1991-2010



COMMENTARY: One output of the HIV/AIDS epidemic model is the evolution of age groups over the years. Graph 10 shows that the distribution of the different age groups and also the dependency ratio of people under 15 and over 65 years of age do not change much over time, even in the presence of a full-blown AIDS epidemic. This is quite a surprising finding, and a very important one. [See further clarification on p.25 – first question.]

SLIDE 8: The most important lessons learnt from the workshop:

- Most of the expertise and data needed to model HIV/AIDS and demography were available.
- Thorough preparation is necessary for compiling available information.
- It was relatively easy to reach consensus once the process was fully understood.
- Capacities have been built to incorporate new information.
- Similar workshops may be helpful for sector-specific planning.

SLIDE 9: Conclusions:

- There is national consensus about the impact of HIV/AIDS on demographic indicators.
- The available data are a sound basis for planning.
- Capacities exist to update and refine the model (working group: contact Dr Forster).
- The modelling programme as well as all the modelled data are downloadable free of charge from the MOHSS website: http://healthforall.net/grnmhss/.
- The number of orphans will increase by a factor of 5 over the next 10 years.
- There will be only minimal changes in the overall dependency ratio. (This of course excludes the ratio within affected households and families, which will experience a major impact in terms of dependency.)
- Some regions are more affected by the epidemic than others, and the most densely populated regions are also the most highly infected.
- Some sectors are more vulnerable than others to the impact of the epidemic (especially the subsistence farming sector, in which there is often a shortage of labour and in which many women are household heads).

SLIDE 10: Response:

- Maintain a sound macroeconomic environment.
- Social cohesion is a major factor determining the course and impact of the epidemic.
- The HIV/AIDS epidemic itself may affect social cohesion.
- Existing solidarity mechanisms should be strengthened to maintain "family life".
- We have to remain decision-focused on these long-term priorities. The long-term impact depends on our present response.

Ladies and Gentlemen –

Economists have identified social cohesion in a given society as one of the most important factors determining the spread of HIV as well as the overall impact of the HIV/AIDS epidemic.

In her opening address the Minister of Health and Social Services highlighted some of the underlying factors that explain the rapid spread of HIV/AIDS in the last decade. Many of these underlying factors were successfully addressed during Namibia's first few years of national independence.

HIV/AIDS, however, has reversed many of these development gains, and the epidemic itself has become the main factor threatening social cohesion. Profound changes are needed and they should be implemented urgently, but most importantly, all interventions should entail a sustained reallocation of human and financial resources to address the needs of affected communities, families and orphans.

The situation calls for leadership to address the HIV/AIDS epidemic with commitment, and to act with a vision that extends beyond the immediate impact of HIV/AIDS – towards a brighter future for generations to come. Such leadership will ensure that the coming generations of Namibians grow up in a society that has strengthened its social cohesion within families, communities, regions, and thus as a nation.

I thank you.

QUESTIONS POSED TO DR VAN DER VEEN

Question: Please clarify the finding that the age group distribution and "dependency ratio" of the under 15 and over 65 age groups will not change much.
Answer: There will be many deaths within the 15-49 age group, and as a result fewer children will be born, but this is due to the combined effect of less people of reproductive age and the impact of HIV on fertility. There will also be fewer people over 65 years of age. In terms of numbers, the impact of deaths from AIDS will be felt within households and families, where they will of course lead to instability, but the general population will not necessarily feel the impact of the number of deaths since there will always be a mass of people of productive age. The impact that the general population would feel lies in the loss of skills. The model (and Graph 10 on p.23) doesn't look at the details of the impact on households and different sectors, and on how they will cope, but only at whether there will be sufficient numbers of people, and it appears that these will not change much, but coping is a completely separate issue.

Question: Regarding the levels of infection, hospitalisation and death in the north-western regions, the figures may be inaccurate since people move around a lot in those regions, so a person diagnosed in Oshana may be hospitalised in Ohangwena, or a person who dies in Oshikoto may have earlier been in hospital in Omusati. Is there any way to get a more reliable picture?
Answer: In reports from hospitals the impact of AIDS will definitely be underestimated in most cases, but the MOHSS has to record the figures from hospitals as is. Thereafter we can look for other information to either justify or adjust what we receive through the health information system. I noted that [Graph 9] does not derive from the model, which is based more on prevalence rather than on the actual numbers of people infected. The report on the modelling workshop [launched on 9 May] will give a more accurate picture of the findings in these respects for each region and for each Sentinel Sero Survey site in each region.

Question: How do you know that a pregnant woman tested in Kavango, for example, is not tested again in Windhoek and again somewhere else if she moves around the country a lot? Are the tests numbered? Do you take the women's names?
Answer: The sentinel surveys are conducted every two years over a period of three months. At each specific site/clinic during that period, when a pregnant woman comes for the first time for a syphilis or haemoglobin test, an additional tube of blood is taken, which is marked with a number, the woman's age – not her name – and the site where the blood was taken. The tube is then tested in Windhoek. When the woman comes for a follow-up visit she should have her antenatal card with her, which gives the information about her first visit, so there is no risk of double testing and counting.

Question: We have many immigrants in Namibia. Are they taken into account in the modelling calculations?
Answer: It is not possible to specify or even to find out where a person comes from. An Angolan woman who is tested in Kavango, for example, will be counted among the Kavango sample. As I have noted, the model is not sufficient for determining the general impact of the epidemic, because in some regions it moves much faster so the impact is greater, and also because a person diagnosed in Windhoek, for example, might end up in hospital in Rundu, so the impact will be on a Rundu household rather than a Windhoek household. We have to be careful not to look only at the national or regional averages and impacts; we have to look more comprehensively, therefore there are other studies that determine the burden at household level and other specific aspects of the epidemic.

Findings of SIAPAC Study on Orphans in Namibia

Dr David Cownie,

Managing Director of the Social Impact Assessment and Policy Analysis Corporation (SIAPAC)

On behalf of the SIAPAC team, I will give a [slide] presentation on the findings of a study titled "A Situation Analysis of Orphan Children in Namibia", conducted by SIAPAC (a Namibian research firm), commissioned by the MOHSS and financed by UNICEF.

On a point of clarification, this was a situation analysis of orphan children, so the addition of "vulnerable children" [to the presentation title in the conference programme] is casting the net a bit wider than the actual study sample. Also, there has been quite a bit of muddling regarding children orphaned by AIDS and orphans in general, and some confusion about terms like "children in difficult circumstances", so it must be noted that this was a study strictly on orphans.

SLIDE 1: APPROACH

- National Key Informant Interviews.
- Local Level Key Informant Interviews.
- Group Discussions with Caregivers.
- Focus Group Discussions with Orphans.
- Group Discussions with Regional AIDS Committees (RACs).
- Case Studies.

COMMENTARY: This study was carried out nationwide about 14 months ago. It was a relatively comprehensive study in that numerous people at different levels were interviewed, i.e. national, regional and community. It also included focus group discussions with caregivers identified by social workers, in other words caregivers already linked to social services, as well as caregivers not known to social workers and therefore not linked to social services. Interviews were also conducted with the children themselves, and the researchers focused generally on children of at least 10 years of age so that they could be more assured of obtaining clear responses. On the whole the children were animated and had much to say.

KEY FINDINGS

SLIDE 2: Who is looking after orphan children?

- Most common: extended family members on both mother and father's side – usually aunts and grandmothers.
- Next most common: adult brothers and sisters.
- Uncommon: child-headed households.
- Uncommon: non-relatives.

COMMENTARY: There appears to be a fairly even distribution of orphans across the maternal and paternal families. Who looks after them seems to depend on who is more proximate, who is best known to them and who is most able to offer them support. Adult brothers and sisters looking after siblings are mostly 18-20 years of age and older. We also encountered some child-headed households, mostly consisting of several children living together; one girl was living alone. There were also non-relatives caring for orphans, and they were almost inevitably immediate neighbours.

SLIDE 3: Are orphan siblings kept together?

- Caregivers noted the importance of keeping sibling orphans together.
- The children themselves noted that they were friends with the other children in the household, including their own brothers and sisters.
- Most orphan siblings seem to be taken in by a single caregiving family, and there is no variation across poor and non-poor households.

COMMENTARY: A key principle recognised in the international literature is that of keeping siblings together to help ease their emotional transition and help them

cope with their new circumstances. In most cases in Namibia this principle is being applied, and it appears that this is so even if the burden on the caregiving household is enormous. Obviously there are some cases where siblings have been split.

SLIDE 4: Do the children adjust to their new circumstances?

- Because the children are usually taken into a familiar situation, adjustment is less problematic than would otherwise be the case. Adjustment problems were reportedly most severe among the children who had been moved from an urban to a rural environment.
- Around a third of the orphans were already living in the caregiving household before their parent/s died.
- The trauma of losing one or both parents did create emotional adjustment problems, but most were reportedly not severe. Caregivers recommended "transitional" counselling.
- Orphans tended to feel that they were well accepted in the new household, and they were not teased by other children for being orphans – neither at home nor at school.

COMMENTARY: One must not undervalue the emotional trauma and problems of the children concerned, but it appears that in most cases they are already well known to the children in the caregiving household and had actually grown up with them, which made adjusting far easier. In many cases the children were already comfortable in their new but familiar environment, and after a period of adjustment they settled in well. In the rural group discussions it was repeatedly noted that urban children, being used to a very different lifestyle, find it difficult to cope with the new cultural environment. Some of the children who were moved to the new household before their parent/s died had been there since they were a few months old, and many for a number of years. Although in many cases they had made the transition due to the impending death of their parent/s, usually they were with caregivers because their single parent went off to look for work or had found work far from home, so their child/ren live with e.g. an aunt. Most children remain in the household that first took them in; they do not move from household to household. The adjustment problems overall appear to be less severe than expected and less severe than the international literature describes. This is a credit to Namibia's caregiving families, who really do seem to be doing the best they can for the orphans. The adjustment problems were said to be most severe during the transitional phase which starts while parents are dying and ends when they die.

SLIDE 5: Do orphan children attend school?

- It is commonly assumed that orphaned children lose access to education, but this was not found to be the case in Namibia at this time.
- Households are going to great lengths to keep their own and the orphan child/ren in school.
- Still, many poorer households reportedly have difficulties raising funds for schooling and draw extensively on extended family networks for support. Some also had to request assistance from school authorities in terms of school uniforms and exemption from paying school funds.
- After a period of adjustment the orphans were reportedly doing well in school and did not perform substantially differently to how they otherwise would.

COMMENTARY: In the international literature schooling for orphans comes up as a very serious concern, and not being able to continue sending them to school is probably the major fear among Namibian caregivers. But most of the children are in school. They may be over-age, they may miss classes, their schooling has been disrupted by parental death, but they are in school, and the children and their caregivers say that even if there is a time of difficulty in focusing on studies, they do tend to rejoin the mainstream even if they are older repeaters. Many of the poorer households drawing on extended family networks were even linking to remote family members with whom they'd had little contact in the past. Thus they were casting their net wider – approaching anyone they could think of and basically going to great lengths to keep the children in school.

SLIDE 6: The extended family clearly plays a key role in caring for orphans. What about neighbours, the community more generally, and NGOs and the Government?

- The international literature highlights the key role played by the wider community in helping to meet the needs of orphans and caregiving households.
- In Namibia, by contrast, asked about the importance of neighbours, CBOs and community leaders helping in this regard, virtually all the respondents stated that presently

they do not play much of a role.
- Support from NGOs and the Government was felt to be more important or potentially important.

COMMENTARY: This is perhaps a controversial issue. Virtually every authority recommends community-based support programmes as the best way to proceed. While this study does not contradict that view, it does suggest that right now both the reach of these organisations and caregivers' expectations of support from them are quite small. The caregivers interviewed were primarily reliant on extended family resources, and they hadn't even thought about what kinds of community organisations could help them. Asked about this, they commonly mentioned churches, but even these they had not really considered as a support mechanism. The study also found that very few caregivers today ask neighbours for support in difficult situations. The perceptions in this regard are changing, and they do need to change, but the study is perhaps pointing out that the transition to community-based care may be far more difficult to bring about than anticipated. There were a number of expectations with regard to government assistance [the speaker didn't give examples]. Also, interestingly enough, quite a few interviewees saw their local political links to be the best option for accessing support in certain situations, and they thought of these links long before they thought of any other kind of community organisation in seeking support outside the extended family. This is only partly due to the fact that some of the respondents were already closely linked to political organisations. In fact, community reliance on these organisations is much broader in Namibia than one might suppose.

SLIDES 7-8: ISSUES ARISING

- Support required: valued at N$250+ per orphan.
- Type of support desired: cash contributions; payment of school costs; food; clothes; blankets.
- 'Most needy' households: those without a wage earner; those without livestock; those looking after many children.

COMMENTARY: Caregivers were asked to try to attach an economic value to the support they would need to raise an orphan in the way they would want to – without being extravagant. Some nonetheless gave amounts like N$10 000 a month, but the most common response was N$250-N$300 per month per child. Asked to try to identify what makes a household vulnerable in terms of its ability to care for an orphan, 58 out of 60 groups identified the same factors and also gave these the same ranking.

- Emotional needs: 'adjustment' counselling.
- Education: keeping children in school.
- What to do: when extended family structures are not enough.
- What to do: child-headed households.
- What to do: community-based interventions.
- Monitoring.
- Child-minding.
- Facilitating adoption.

COMMENTARY: Adjustment counselling was identified as a need while parents are dying until they pass away; most respondents felt that children are able cope thereafter. Every respondent desperately wanted to keep the children in school; none saw any alternative to formal education and they don't even want to know of any. In the international literature there is a big debate on the issue of monitoring: how and why to monitor, what to do with the outcome and how reliable it is. On the issue of child-minding, it is clear that with additional children to care for, many households can no longer undertake activities that they previously did, e.g. agricultural activities. This is often the case for elderly household heads, and many respondents felt most desperate about the fact that young people in the household cannot go out to look for work because they have to look after young children. On the issue of facilitating adoption, where children are informally taken in by extended family households, neighbours or community members, these 'adoptions' are not being formalised, and as anyone who has been through the formal adoption process will know, this is an enormously difficult, complex and mysterious process. If fewer and fewer extended family structures are able to cope, how is Namibia going to respond to the fact that these children will have to be taken in by non-biological family or community structures?

Dr Cownie had produced an overview of the SIAPAC findings, copies of which were distributed prior to the working group sessions on the second day of the conference, to guide the groups.

QUESTIONS POSED TO DR COWNIE

Question: How did the respondents arrive at the amount of N$250, and is there any regional variation in the amounts requested?
Answer: This is a resource value or an anticipated economic need, not an actual request for that much per month. We asked caregivers to attach a reasonable numeric value to their economic needs if they were going to care for an orphan as they would like to, and this is the amount they say they need. I should point out that the children are no longer eating as much each day nor the same types of food as before, and they are struggling to buy school books and uniforms, so they are not actually receiving the value of N$250 per month from the extended family structures at present. We did expect to see regional variation in the responses to this question, but there wasn't much; there were only slight variations in responses from urban areas, where costs are higher. If the MOHSS is thinking along these lines, I think N$250 per month per child may be seen as a reasonable amount. Botswana is currently issuing the equivalent of N$500 per month (i.e. 300 Pula).

Question: Why are children living alone? Have all their relatives died, or have their relatives denied them a home, or do they just not want to live with anybody? Also, where in the country were child-headed households found?
Answer: Only a few child-headed households were found. It is difficult to say precisely where they are and what their particular situations are, but I would say that more were found in the south than elsewhere. We do know that their situations vary according to location and culture. The only child found living alone was a 15-year-old girl in Opuwo, whose daily routine consisted of waking up and tending to livestock, going to school, returning home, very diligently doing her homework, then tending to the animals again. It's unclear why she was living in such circumstances, but she was not in a 'poor' household since financially she was coping well, and she had a strong will and drive to get on with her life. We found child-headed households whose links with extended family households were too weak for the children to be taken in. It seems that the children live on their own for a couple of years, or maybe only a couple of months, before a non-relative like a neighbour or an extended family member like an aunt or uncle takes them in. We also found that their most vulnerable and difficult time is indeed the time they spend by themselves.

Question: How willing are non-relatives to take orphans in? Are they really willing to do so?
Answer: We found very few children living with non-relatives, and to most caregivers we talked to, the notion of non-relatives taking in orphans was alien and "silly"; they are not expected to do this, nor is it considered important that they do. In most cases we found, the children were simply left on their own, and realising this after a period of time, a neighbour took them in, but this seems to happen only if the children are found to be in exceptionally difficult circumstances. This is likely to come up as a serious issue 10 years from now, which is why I noted it as a challenge in terms of community care.

Question: If it becomes a major problem that children are not automatically taken in by an extended family or neighbouring household, are there any plans for or is there already a register that tells councillors or social workers exactly who the orphans are in their area?
Answer [from Ms Coetzee-Masabane]: In certain parts of the country there are individual staff members of government offices or other organisations keeping a register, but there is no official national register as yet.

Question: Did SIAPAC find any link between the size of the inheritance left by a deceased parent and the willingness of people to care for their children?
Answer: No. Inheritance does not appear to be a deciding factor, though it may come into play in some cases in terms of who takes the children in. Proximity and history of interaction seem to be the primary determinants. We did ask caregivers if the dying parent/s had made any financial provision for the transition, and in most cases they had not. Usually, in fact, all the household's money and other assets had been consumed in efforts to cure the parent/s or at least to make their last days comfortable. We also found no link in terms of property that could still be sold off. Inheritance simply didn't emerge as an issue of importance to anyone. This is presumably good news for the MOHSS.

Psychosocial Issues Facing OVC in Namibia

Ms Khin-Sandi Lwin,
UNICEF Representative in Namibia and
Chairperson of the UN Theme Group on HIV/AIDS

The information I will present derives from the Eastern and Southern African Regional Workshop on OVC held in Lusaka, Zambia, in November 2000, and from global studies. The workshop in Lusaka came up with a rich set of reference materials which can be made available. Also there is a very good manual that Terres des Homme produced while working in Tanzania, which would be very useful to anyone working on OVC issues in Namibia.

SLIDE 1: Holistic approach to OVC care (all three are essential):

- Physical care: addressing adequacy in terms of material needs (i.e. shelter, food, clothing).
- Transfer of knowledge and skills for sustainable self-help and development (i.e. education, vocational training, life skills).
- Psychosocial care and support.

COMMENTARY: Namibia has not yet addressed the need for life skills training for adolescents, who are increasingly going to need parenting and household management skills especially.

SLIDE 2: What are some psychosocial issues facing OVC?

- Coping with grief and bereavement.
- Greater social isolation, stigmatising and discrimination due to HIV/AIDS infection.
- Need for social protection given the greater risk of lack of care and of exploitation.
- For some, greater risks of longer-term anti-social behaviours and aggressiveness if special care is unavailable.

COMMENTARY: Most critical here is the issue of social stigma, isolation and discrimination. This will be a new element of any programme targeting orphans generally. Regarding anti-social behaviours, anger about one's parents having died, along with fear and anxiety, are probably the primary underlying causes.

SLIDE 3: Why we need to provide psychosocial support:

- "To protect the capital of social energy, motivation and self-confidence of the children for their own and society's benefit." In other words ...
- Children need that extra helping hand to regain

their 'balance' in life when one or both of their nurturing/supporting 'crutches' disappear. Without this help society may end up with more unproductive and anti-social adults in the long run.

COMMENTARY: The concept of "social energy" encompasses five defined elements: (1) self-consciousness – the ability to understand one's own feelings and moods, and to be confident; (2) social steering – the ability to control and divert a violent-tempered stimulus and to think before acting; (3) motivation – the attitude one takes to pursuing goals and the ability to persevere; (4) empathy – understanding the situation and feelings of others; and (5) social competence – the ability to make contact and build relationships. Without the necessary initial nurturing, these are the qualities that can be lost in a child. At this point I would like to read you an extract from a book by Claudia Jewett titled Helping Children to Cope with Separation and Loss, which encapsulates in a nutshell the child's experience of loss. [The quotation is recorded on p.15 of this report.]

SLIDE 4: Four areas of possible reaction to loss of a parent:

- Emotional life: sadness, loneliness, guilt, anxiety, anger (the latter possibly leading to overactive, aggressive, fearful behaviour).
- Self-perception/image: loss of self-efficacy (influence or control) and self-esteem (worth), leading to withdrawal, allowing others to exploit – exacerbated by the discrimination or stigma of HIV/AIDS – or greater sense of maturity in the long run.
- Health: with greater and acute stress and internal turmoil, greater chances of psychosomatic symptoms (headaches, stomach problems), real illnesses or becoming accident prone.
- School performance: greater difficulties with learning and concentration.

COMMENTARY: I would like to point out that the SIAPAC study on orphans was not meant to be a psychosocial investigation, so it may lack depth in this regard and the respondents' assertion that children do not have problems after the initial stage must be taken with caution.

SLIDE 5: Different levels of reaction:

- Depending on age and sex (of parent and child), preparation, level of independence, vulnerability, innate resilience, availability of close alternate source of emotional care.
- Effects may not surface until years later for some children.
- Depending on risk factors.

COMMENTARY: The reason for the international definition of an orphan being a child who has lost her/his mother is that the mother is the primary caregiver, so the nurturing element disappears upon her death, whereas a father's death has more of an economic impact – this unfortunately being the reality, though we should aim for stronger paternal involvement in child-rearing in the long run. This is why the effect of a mother's loss tends to be stronger.

SLIDE 6: If these four risk factors coincide, some form of disorder in development or behaviour will almost inevitably result:

- Terminal illness of a parent (i.e. not sudden death).
- Separation from siblings.
- Exclusion from or discontinuation of school.
- Poverty/deprivation.

COMMENTARY: Clearly there is a very strong possibility that these risk factors will coincide in many cases in Namibia.

SLIDE 7: Levels of vulnerability:

- Past experience: repeated loss can make a child more vulnerable, but perhaps less vulnerable if a strong and nurturing family environment existed.
- All ages are affected (also infants), but for emotional stress, children aged 5-7 appear to be more vulnerable – they are old enough to understand permanent loss but lack the social skills to deal with it (to express or externalise feelings).
- Girls are more vulnerable to social risks given their social status and economic dependence. They are at greater risk of sexual exploitation and abuse.

SLIDE 8: What can/should be done:

- Help child recover from shock of loss.
- Make child aware of her/his own resources and strengths.
- Help child overcome feeling of helplessness and that there is no future.
- Help child maintain/develop self-esteem and self-confidence.

- Make child aware that society/community hasn't abandoned her/him (educational and physical/material support).

COMMENTARY: These are the areas of help that the psychosocial care package should incorporate. Older children especially experience hopelessness about the future when the assets of a household start disappearing.

SLIDE 9: How these things can be done – within the family circle:
- Preparation for death: helping the dying parent to cope and preparing the child emotionally.
- Give clear and understandable information (lack of which creates greater anxiety and a feeling of being less important or even responsible for the death).
- Ensure involvement/inclusion – in both preparation for death and death rituals.

COMMENTARY: Preparation for death really means opening up to allow for support for both parent and child. In a lot of cases there is no discussion of the impending death and potential problems for the child, and this blocks support at a crucial stage. Keeping children in the dark, or keeping them 'safe', actually increases the negative effects on them. Given the ethnic and cultural diversities in Namibia, efforts to involve children in rituals should be ethnically and culturally sensitive rather than standardised.

SLIDE 10: External support by communities or services:
- As part of a home-based care package for people living with HIV/AIDS.
- Through specific group or individual psychosocial support activities (e.g. of schools or NGOs).
- Ensuring continuation of routines (especially schooling) for stability, and additional support in school from teachers.
- Ensuring safe structures or environment (keep siblings together – especially if they are moved from an urban to rural setting or vice versa).

COMMENTARY: In providing home-based care one develops a relationship with the family, and this provides the opportunity for psychosocial support.

SLIDE 11: Who can provide this care?
- The first circle of care must be the family (nuclear or extended), but caregivers need support in learning to cope with their own stress and with the children.
- Church structures and local/community-based groups are most capable of providing this support, but their capacity needs to be strengthened.
- Schools can provide emotional support and outlet (teachers, friends, extra-curricular activities). Play and art (e.g. drawing) for younger children are strong tools to help children recover from trauma.
- Ultimately NGOs and government outreach services have to help build the capacity of communities and schools to provide support to children.

COMMENTARY: That the first circle of care has to be the family is a core principle of the UN Convention on the Rights of the Child. On the role of churches, the Lutheran Church should be challenged – as Minister Amathila did in her address – to do more for people affected by HIV/AIDS. There are very many Lutherans in Namibia and their church could be a central provider of psychosocial care since this also involves spiritual support. Regarding schools, playing and drawing are very helpful tools for dealing with trauma in children aged 5-7 years especially. We use these in providing psychosocial care to children affected by war. Though they don't entail psychological interaction per se, these activities draw out the emotion inside.

SLIDE 12: 'Other' vulnerable children:
In situations of child abuse (physical, sexual) and gross neglect for various reasons, the psychosocial effects are of a slightly different nature: in cases of abuse the effects are very serious, but the caregiving elements are similar and the same community and services should respond with professional psychological care where available.

There were no questions from the floor.

The OVC Situation in Zambia

Ms Mulenga Kapwepwe,
OVC Consultant in Zambia

In this presentation I will attempt to give a comprehensive overview of the OVC situation in Zambia by describing the development of the Zambian response to the situation over the past decade.

BACKGROUND

In the mid to late 1980s Zambia recognised HIV/AIDS as an epidemic that was ravaging its people. The fact that a large number of adults were dying was becoming an accepted tragedy. Quite early in the epidemic interventions such as safe blood supplies, sexually transmitted disease control programmes, behavioural change communication, condom promotion, voluntary HIV testing and counselling became the backbone of the Zambian response. Also, sentinel surveillances and studies in various critical areas were commissioned to track the impact and cost of the disease.

But the true meaning and magnitude of the epidemic had not yet been perceived. The impact of HIV/AIDS on Zambia's children was becoming visible in many ways as many of them lost one or both their parents to AIDS. Increasingly children were not attending school, not receiving proper nutrition and not accessing health care. By 1996 the situation had become critical.

While the battle against HIV/AIDS was being waged in these early years, the economic battle was being lost, and human poverty increased in Zambia (SADC Human Development Report 1998). By 1999, 80% of the population was living in poverty, and the dynamics of poverty and HIV/AIDS were starting to be felt.

In the early 1990s the first signs of the tragic impact of poverty and HIV/AIDS on children started to be seen and felt. More and more children were encountering difficult circumstances and being abandoned, while school enrolments were dropping.

Malnutrition cases and child mortality rates were rising.

Data on children in Zambia:

- In 1996 there were 4.1 million children under the age of 18 in Zambia.
- According to the 1996 Living Conditions and Monitoring Survey (LCMS) data, 13% (i.e. approximately 550 000) of Zambian children were orphans.
- Single orphans (i.e. 86% of all orphans) outnumbered double orphans.
- 64% of orphans had lost their father, 22% their mother and 14% both parents.
- The proportion of children orphaned increases with age – from around 4% aged 0-4 years to 19% aged 10-14 and 23% aged 15-18.

Levels of poverty:[1]

- Nearly 70% of Zambians lived below the poverty line in 1996.
- The number of people living in poverty in rural areas is considerably higher than the number in urban areas.
- In 1997 per capita income was US$308.
- Nearly three quarters of Zambian children live below the poverty line in the late '90s, with little notable quantitative or qualitative difference between orphans/vulnerable children and others.

School attendance:

- Nearly half of Zambian children are not enrolled in primary school, regardless of orphan status.
- Countrywide there is little difference in the primary school attendance rates of orphans and non-orphan children.

[1] LCMS 1996; SADC Human Development Report 1998.

Homeless children appeared on the streets, staying there to beg or work for food or money for themselves or their families.

The strain on the family, particularly the extended family, began to show. At funerals children were increasingly being disinherited, poverty levels and new materialistic consumer cultures increased property grabbing, and cultural practices of widow and/or child inheritance were disappearing. The form and composition of the family began to change: the number of child-headed, single female-headed and grandparent-headed households was increasing; relocation and displacement of children from home to home was increasing; and adult siblings were taking over the parenting of younger siblings in their own households.

Other social ills that began to flow from the epidemic during the early years included child abuse, ~~widows and children being left without any property~~ and shelter, and the erosion of children's rights.

Nutritional status of orphans:
The data demonstrates that 56% of orphan children and 49% of non-orphan children are stunted.

Street children:

- The 1998 SADC Human Development Report estimates that 75 000 children in Zambia are street children.
- Over two thirds are children aged 6-14 years.
- The majority are boys.
- 40% of street children have lost both their parents.
- It is estimated that 7% of street children have no home to return to.

Characteristics of Zambian households with orphans:

- Nearly half of all orphans live in a household headed by a surviving parent.
- From the categorisation of orphans as 'maternal', 'paternal' or 'double', it is clear that in Zambia grandparents and aunts/uncles look after a large percentage of double orphans: grandparents look after 38% of double orphans and aunts/uncles look after 29% of them. This demonstrates that the extended family continues to share the burden of orphan care.
- In rural areas double orphans are more likely to be cared for by a grandmother, and in urban areas by aunts and uncles more than other relatives.

THE 'FIRST-GENERATION' RESPONSES

One of the first conferences held to evaluate the escalating crisis facing our children was the conference titled "Support to Children and Families Affected by HIV/AIDS" held in 1994. At that time the problem was seen to be very much an HIV/AIDS-related one. The questions posed were those of paramount importance in everyone's mind: what exactly was happening to our children as a result of the epidemic; where was it happening the most; and why? There was the problem of definition: who was an orphan; would we focus only on orphans affected by HIV/AIDS; should different categories of orphans be treated differently; how would we direct our efforts if we did not agree on who exactly needed help? Also, what living spaces should we encourage stakeholders to develop for such children – orphanages, AIDS orphan homes ... ? What alternative solutions could we support in terms of shelter? And still further, what could we do about the problem of orphans not being able to remain in school? Fragmentation of family units due to poverty and death was another major concern. How could we go about ensuring steady sources of household income to keep families together? The underlying issues of poverty and death, and the resultant precarious situation facing children, were surfacing.

Responses to these questions at that time were typically focused on shelter issues; ways to provide financial and material support to communities and families; supporting home-based care efforts; helping orphans to gain access to education and vocational training; identifying income-generating activities; and accessing legal support for and undertaking legislative action on behalf of orphans and widows.

HOW ZAMBIAN SOCIETY RESPONDED

Families and communities were in the front line of the impact of HIV/AIDS and poverty on children, and they responded first. Quietly, families were taking in orphans, supporting relatives with children materially as well as psychologically, and reorganising their own financial bases to cope with the worsening burden of extra care and support for children.

Whether communities openly discussed HIV/AIDS or not, they were still living fully in the realities of the health- and welfare-related problems caused by the epidemic. Several communities took steps to start initiatives that could address the issues,

and they also sought to devise means to sustain such activities. More and more community groups and individuals started assisting needy families and neighbours financially, materially and psychologically, and generally sharing the multiple burdens of social and material need. To survive economically, many orphans and caregivers engaged in small-scale income-generating activities such as selling vegetables or commodities in the local market or at the roadside, or taking on menial work for better-off families in their communities.

Next to react were the community-based organisations, and most notably the churches. Withing their parishes and congregations, the problem facing children was becoming clearly visible. The churches had a mandate to help the poor, and they soon started developing initiatives to help poor people directly affected by the epidemic. Religious institutions with an extensive outreach, such as the Catholic Church, developed coordinated family-care programmes quite early on, and many other churches began encouraging orphan care among their congregants. Though the churches made commendable attempts, in general the church- based programmes lacked large-scale funding and a focused programme effort.

The urgent need for Zambia's Government to provide policy and leadership was certainly being taken seriously, but due to budgetary constraints the Government was slow to react to the problem. Budgetary shortages grossly limited the active role that the Government could have played at that stage in helping to ameliorate the situation of orphans and other vulnerable children. Government funds for social welfare assistance were reaching only a small percentage of the intended target population. Though the relevant ministries did develop policies on children, implementation and enforcement of these were inadequate. NGOs increasingly began taking over where the Government could not perform.

NGOs and CBOs close to the ground saw the problems and started trying to assist. At that time, however, NGO interaction with the communities had not yet reached the level of experience where a new understanding of the problems could lead to real community-led initiatives. Advocacy and fighting for children to stay in school, acquiring funds to finance schools and school fee waivers for orphans, and setting up informal education systems were some of the early NGO responses. Some NGOs, such as the Young Women's Christian Association, also played a role in accessing legal support for widows and orphans, and in pressing for the repeal or amendment of obsolete child-related legislation. Very soon Zambia's NGO community began filling the gaps in areas where there were limited direct government resources. NGOs and CBOs began implementing very extensive donor-funded activities aimed at mitigating the suffering of vulnerable children. But at that stage NGOs and CBOs were not coordinating their efforts, nor sharing information, nor meeting to discuss the OVC issue and solutions. Questions regarding the quality and impact of services were largely left unanswered. The high numbers of NGOs and CBOs that responded, and the high speed at which they did so, were not conducive to producing a coherent, collaborative, coordinated and well-documented response to the crisis facing children in Zambia.

THE DEVELOPMENT OF THE RESPONSE TO THE OVC SITUATION IN ZAMBIA

The first-generation responses that I have outlined were very much directed at meeting the physical/ material needs of orphaned children. They were also very localised and immediate responses. Programmes implemented were quite often focused on giving direct assistance in the form of financial and material relief, and organising communities to find ways of doing this. First-generation responses – like those developed by an NGO called CINDI – typically assisted communities to develop localised bursary schemes, which in turn depended on either outside funders or income-generating activities at community level. CINDI also began mobilising communities into committees of neighbours, friends and teachers to serve as foster parents and to assist families with their day-to-day needs. A number of NGOs focused their efforts on providing for the physical well-being of children, by way of giving out clothing and food and establishing drop-in centres. Two agencies were engaged in providing food aid, namely the Programme Against Malnutrition (PAM) and the World Food Programme (WFP). Organisations like World Vision International were involved in providing school bursaries. Very soon the NGOs and CBOs realised that direct and material or financial support could in fact create relations of dependence, and that communities must somehow be involved in mobilising their own resources. Enhancing the capacity of communities to attain financial autonomy was therefore seen to be the most desirable course of action.

At this stage – until about 1997 – the problem of

definition was still unresolved: who was an 'orphan'; which children should be helped? Various definitions were being applied, with hardly any consensus. Most of them had been developed by technical programming experts. The definitions of 'vulnerable child' were based mainly on a set of livelihood indicators; some merely distinguished by age (e.g. under 15 or under 18) and by whether one or both parents were deceased. But taken to the communities, these definitions were seen to have value only for distinguishing between orphans and other vulnerable children when considering statistics, psychological support, rights protection, interventions for those with the specific status of 'orphan', and epidemiological surveys. In fact NGOs and CBOs soon found out that using any of these definitions as their sole guide for deciding who to help carried significant risks, because it meant that some children would be overlooked, and because agencies applying the definitions in their work with children at community level tended to focus exclusively on orphans rather than on all children in need.

A crucial lesson was learned at this point; it shifted the entire focus and scope of all interventions for children in Zambia from this point forward. It was learned by listening to the community perceptions expressed during participatory methodology workshops aimed at helping the communities to identify specific problems and solutions. Most communities did not differentiate between orphans and other vulnerable children. On the ground, orphans constituted a growing group in all Zambian communities, but in extending community care and support to them in whatever form, there was no practical way of separating the orphans from the other vulnerable children, whose precarious circumstances were almost the same. Community definitions showed that where there are large numbers of vulnerable children – as is the case in Zambia – separating one group from another is simply pointless – hence the adoption of the term Orphans and Vulnerable Children (OVC). So, interventions had to acknowledge the existence of orphans, but also the fact that all children in vulnerable situations were living in a very similar set of circumstances. The lesson learned was that when it comes to developing practical interventions, it is best left to the communities to identify who is an orphan, who is vulnerable and who requires what assistance. Responses or definitions may vary from region to region or locality to locality, but the important thing is to listen to the community. Statistics have proved community definitions of orphanhood and vulnerability to be more accurate than any template definitions, which means that community definitions can direct assistance in a more focused way.

Nonetheless, NGOs quickly realised that despite the financial and material assistance directed to individuals or families to alleviate their poverty, very few activities were actually started, most IGAs were unsuccessful, and money given as grants was neither invested nor reinvested, but rather used to buy food or pay debts or cover medical expenses, and dependence was prolonged. Thus in the second phase of the response, organisations decided to take a more sustainable approach to their work in the OVC arena: they would focus on building an enabling environment for communities, families and individuals to cope by themselves, and this would entail building specific community capacities and mobilising entire communities to action, so programmes for OVC started focusing on:

- building the capacity of families to care for their own OVC;
- enhancing community mechanisms for

The socio-economic status of Zambian children:

- Children in Zambia face economic vulnerability in large numbers.
- There is little difference in economic status between orphan and non-orphan children (75% of orphans are found in households living below the poverty line, as are 73% of non-orphans).
- There is little notable difference in the situation of orphans living in poverty in rural and urban areas.
- Nearly half of Zambia's children are not enrolled in primary school, regardless of OVC status.
- Countrywide there is little difference in the primary school attendance rates of orphans and non-orphans.

Voice from the community: who is an orphan?:

- A focus group in Chintankwa, Serenje, agreed that an orphan is a mulanda, i.e. a vulnerable or suffering child who has no parents.
- A focus group in Sawmills, Livingstone, agreed that an orphan is a child who has lost his/her father or both parents. A child who has lost his/her mother was not seen to be an orphan per se.

supporting vulnerable households;
- helping older children affected by HIV/AIDS to support themselves and their younger siblings;
- lobbying and advocating for government to support OVC by providing leadership, policy and essential services; and
- raising public awareness of the needs and problems facing OVC in Zambia.

The OVC programmes were underpinned by a concerted effort within NGOs to build their own capacity in participatory methodologies, resource mobilisation, advocacy and lobbying, project planning and management, community approaches and social work.

The NGO programmes for OVC henceforth incorporated skills training in fields such as leadership, business administration, programme monitoring and evaluation, nutrition and health care, as well as education on HIV/AIDS, gender equality and so on. Some NGOs also made efforts to link the communities to outside resources such as donor agencies or district governments.

So the cornerstones of NGO programming for OVC became, and remain: mobilisation and capacity-building to foster community ownership, responsibility and sustained action; education – provided mainly by community schools; and income-generating activities.

Stakeholder identification exercises were undertaken, and new actors to enter the OVC arena included parliamentarians, traditional leaders and business enterprises. Strategies for involving these and other new partners were evolving at the same time. Lobbying and advocating for the Government to protect OVC and to provide leadership, policy and essential services began in earnest.

The Government was seriously alerted to OVC issues by studies like the UNICEF OVC study conducted in 1999. Many of the findings and recommendations of such studies were eventually incorporated into the objectives and mechanisms of the Zambia Social Investment Fund (ZAMSIF). Another positive development towards the end of the '90s was the formation of the Government's Task Force on OVC. This body is composed of: the Ministry of Youth, Sport and Child Development; the Ministry of Community Development and Social Services; the Ministry of Health; the Ministry of Education; the Ministry of Legal Affairs; and some umbrella NGOs, religious institutions and civic organisations. Also, the Disaster Management and Mitigation Unit (DMMU) in the Office of the Vice-President began to critically examine its role in caring for OVC.

At this stage of Zambia's response it was realised that the existing interventions were not paying sufficient attention to the psychosocial needs of OVC; they needed to become far more cognisant of the trauma caused by the loss of parental support. But the response to calls to initiate solutions to this problem through the existing programmes was slow. The first responses focused on home-based care, but it was soon realised that the home-based care efforts all needed an infusion of specialised skills in counselling and applying other psychosocial support mechanisms.

THE CURRENT STAGE OF THE RESPONSE

Over the years more and more organisations have responded to the OVC situation, and there have been many positive new developments. The most recent National Conference on OVC revealed that Zambia has reached the stage of redefining and aligning strategies, standardising programming and care practices, and identifying who is doing what. We are also now advocating for geographically located councils and coordinating and monitoring bodies to ensure a coherent, collaborative, coordinated, quality and properly monitored response.

The direction and pattern of interventions for OVC in Zambia are now based on our most important learnings during the long process of defining OVC and their specific needs:

1. OVC poverty is a primary problem.
2. OVC have special psychosocial needs.
3. The OVC issue is a family and community issue.
4. The OVC issue, like the HIV/AIDS epidemic, requires the formation of partnerships and a multi-sectoral response, and all sectors have to be involved.
5. A protective, responsive and supportive legal or legislative environment has to be created to advance the resolution of the OVC problem.
6. Efforts to stem the spread of HIV/AIDS and to care for parents or guardians living with HIV/AIDS must be incorporated into OVC programming.

I will proceed to elaborate on these most important learnings.

OVC poverty is a primary problem

The Zambian Government in conjunction with NGOs is currently trying to establish income-maintenance and/or material support systems to serve needy families and individuals. At the national (government) level the Public Welfare Assistance (PWA) scheme has been revamped, and will now be piloted in 9 districts. This will be carried to another 27 districts in 2001, and to the remaining 36 districts in 2002. Taking cognisance of the lessons already learned, the PWA scheme requires that the communities themselves identify welfare beneficiaries; that they decide on and control the resources; and that they are accountable for the resources. The PWA scheme is intended to complement traditional social norms and customs. PWA administrators will also work through NGOs and CBOs to help build capacity in resource management, to sensitise people to poverty- and welfare-related issues, and to plan and develop guidelines for activities. Through the PWA scheme additional resources are being sourced and managed, for example funds to cover education bursaries and health care for children aged 6-16 in six target districts.

OVC have special psychosocial needs

The College of Health Sciences in Chainama is now providing counselling training and developing counselling techniques that are more culturally relevant and sustainable. A newly established national counselling body will help ensure standardised and high-quality counselling practices, and also monitoring of counselling. International organisations such as AIDS Alliance are complementing national efforts to identify counselling needs, and to establish more counselling centres around the country. Umbrella NGOs such as Children in Need (CHIN) periodically offer their members child-counselling courses. In fact CHIN has produced a child-counselling manual for use at community level. The psychosocial support provided by extended family and community members is proving to be extremely valuable. The current availability and scope of psychosocial care is being examined. It appears that in general in Zambia, community members are tremendously supportive of one another, particularly in times of need. A community counselling model developed in Chikankata has proved very successful. Perhaps the most important aspect of this model is its teaching that all community members can help with counselling – using informal traditional or formal techniques.

The OVC issue is a family and community issue

The Government has allocated ZAMSIF funds to alleviate OVC social problems specifically. These allocations help to ensure, for example, that siblings stay together after their parents die, that they remain in their own community and even in their own home as is sometimes possible, that caregivers have access to skills training, and that OVC have access to health, education and other services. There is also a specific ZAMSIF allocation for enhancing the capacity of NGOs and CBOs to address OVC needs. This allocation supports community-based policies on OVC, community-based OVC identification mechanisms, community-based projects for OVC, as well as efforts to make information and OVC programmes accessible to all caregivers and other stakeholders. This allocation also encourages NGOs and CBOs to make proposals on ways to address the specific problems of OVC. The priority areas of support at present are: training of trainers in home-based care and counselling; training of district staff to facilitate the compilation of community OVC registers and the establishment of more community-based pre-schools for OVC; and teacher training for community and mainstream school teachers at schools that support OVC education as a specific focus. ZAMSIF funds are also used to improve the means of production and the financial and household food security of target groups, and most especially those of households headed by women, grandparents and children. OVC centres that offer a safe haven or temporary shelter will also be supported by the ZAMSIF funds in future. Lastly, there will be a ZAMSIF allocation for making OVC assessment an integral part of all surveys on household living conditions, and for updating the 1999 OVC situation analysis.

The OVC issue, like the HIV/AIDS epidemic, requires the formation of partnerships and a multi-sectoral response, and all sectors have to be involved.

A multi-sectoral district response model has been developed, and organisations such as SCOPE are furthering the work in this regard. They are now busy catalysing eight districts to form District OVC Committees constituted by NGOs, CBOs, religious organisations, local and national government bodies, and role-players in the private sector. Multi-sectoral involvement in prevention and care now forms the basis of most other interventions, like the OVC programme in Chikankata, which offers training

courses on OVC issues for other NGOs and CBOs. Though religious institutions are becoming more systematic in their efforts to support OVC, they still need to be strongly supported by other roleplayers. Private sector initiatives are now evolving, and enterprises such as the Partnership Forum have already reaped some success in creating sustainable business or income-generating opportunities for different communities. For example, the Forum helped farming communities in the Eastern Province to form partnerships with supermarket chains such as Shoprite.

A protective, responsive and supportive legal or legislative environment has to be created to advance the resolution of the OVC problem.
Concerted efforts are being made to promote the integration of core provisions of the UN Convention on the Rights of the Child (CRC) into the OVC legal or policy framework in Zambia. UNICEF has also undertaken efforts to popularise key legislation providing for the protection of women's and children's rights, and to make the CRC accessible to Zambian communities. Obsolete pieces of legislation like the Juvenile Act are now being revised, and others are under review. Also in this vein, serious attempts are presently being made to strengthen the capacities of key government institutions to plan effectively together with all other key stakeholders for building an enabling environment through enhanced coordination, policy guidance and overall leadership. There is a National OVC Steering Committee in place, its terms of reference have been developed, and one of its first tasks will be to facilitate the development of a National OVC Policy.

Efforts to stem the spread of HIV/AIDS and to care for parents or guardians living with HIV/AIDS must be incorporated into OVC programming
At the outset of the OVC response in Zambia, there were almost no interventions targeting children at risk of being orphaned by AIDS and/or at risk of becoming 'street children'. Also, there were no responses at that stage to the need to assist parents or guardians living with HIV/AIDS, or more specifically to provide the care and treatment necessary to prolong their lives, and hence to ensure that parental care for their children would continue for as long as possible. Today there are interventions such as the Anglican Street Children's Project, which targets a particularly vulnerable neighbourhood – divided into zones – where Care and Prevention Teams (CPTs) are responsible for looking out for and assisting households to look after the children, and in doing so to make sure that children do not lose hope and leave the family setup. The CPTs care for the families in which parents are chronically ill, their primary aim being to hold the family unit together for as long as possible. Prevention and care for people living with HIV/AIDS have finally been incorporated into OVC programming at large. In the face of HIV/AIDS we cannot prevent children being orphaned, but we can prevent them from falling out of the family and community safety nets, we can delay the onset of orphanhood, and we can help to maintain the quality of life of children through psychosocial and nutritional care for the whole family and treatment for ailing parents.

CONCLUDING STATEMENTS

Despite the many lessons and gains over the years, there is still much to be done to sharpen as well as broaden our response to the OVC situation in Zambia. Theme discussions at the National Conference on OVC in 2000 taught us that we have not yet found the best way to help families sustain themselves, nor the best way to provide psychosocial support to children, nor the best way to mobilise communities to support OVC, nor the best way to strengthen institutional care.

I have described the Zambian response to the Zambian situation. You will be developing the Namibian response to the Namibian situation. Developing a national response entails a very long process of learning, assessing and revisiting strategies and options. In Zambia we battled to get the Government involved. Your strong government response and the fact that your Ministry of Health is spearheading it are definite advantages, as is the fact that you are not creating new structures but rather aligning and strengthening your existing structures. We need to do this in Zambia too. Remember that problems you identify today will not disappear, and changes noted within each structure have to be fed into the national response continually. Conferences like these are very beneficial as they enable the structures to formulate a shared vision and set the direction in which all will move together. I wish Namibia the best of luck in tackling the OVC issue. I thank you.

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QUESTIONS POSED TO MS KAPWEPWE

Question: How have traditional institutions in Zambia contributed to the response on OVC?
Answer: We have a very well-defined traditional government structure, but at the start of the response it was not tapped very effectively. Today we see chiefs and headmen playing a major role in identifying vulnerable people and dispersing assistance to them, and generally in mobilising communities to action. These leaders have a mandate and authority over the people that they still exercise very actively. In fact, starting a project in any part of Zambia without the consent of the relevant traditional leader can spell disaster.

Question: How exactly is the business sector contributing to the Zambian response?
Answer: Businesses have provided funding to community committees for starting income-generating projects like vegetable gardening. One community vegetable-gardening project is earning about 7 million Kwacha per week; this is one of the most successful business- community partnerships we have seen so far.

Question: Can you give an example of how support is channelled to OVC at the household level and the actual impact of this?
Answer: The first responses were to provide financial and material assistance or grants directly to households or families. This was done by organisations like CINDI. The CINDI initiative entailed mobilising a community to grow vegetables or make candles or whatever income-generating activity the community itself decided on, and the

community itself decided who among its members should get the money generated. This process taught us important lessons for monitoring and evaluating projects at community level, because communities use very simple methods to determine who is most in need. For example, they would say, "There has been no fire in front of that house for a long time, so the household has no food." The Public Welfare Assistance (PWA) Scheme also uses communities themselves to identify the households most in need. The PWA works through Community Welfare Assistance Committees, and allocates grants directly to the households they identify. Zambia focuses on encouraging communities to mobilise themselves to raise funds, and then to identify the beneficiaries. We have found that pumping money into communities from outside is largely unsustainable.

Question: Who exactly brought the idea for a national response on OVC?
Answer: As I noted, the problem made itself very visible. In Windhoek I do not see children on the streets, whereas in Zambia you see them everywhere; they are sitting on the roadsides and sleeping in the gutters ... . The problem was in our faces every day. Everyone knew that something had to be done, but I have tried to convey how we battled to find the appropriate response and identify the children we had to help. In tackling the legislative issues, I recall one predicament that drove the Government to act: no ministry was taking responsibility for burying street children who died. A society must question itself if it can't bury its dead. It was a problem felt at every level; something that moved everybody to action. No particular sector decided that a response was needed.

Question: I am concerned that this conference still hasn't defined who is an orphan. Surely this should be our point of departure.
Answer: It took us at least two years to arrive at a definition. You would be doing very well to arrive at one in just two days.
Addition from Ms Coetzee-Masabane: We do have a definition; it is a government-endorsed definition that was arrived at after several years and numerous sessions involving all the FLEP partners . You will find it in the handout titled "For the Love of Children". This is Namibia's definition and this is what the working groups should work with. We could perhaps decide that there is a need to review the definition we have, but let us not waste time here by starting the defining process all over again.

Question: What role has Zambia's Ministry of Education played in the response. Also, can you outline Zambia's school fee structure and say how people deal with paying the fees of OVC?
Answer: Education was among the areas worst hit by HIV/AIDS. One of the first signs of the OVC crisis was their inability to access education, and this was a double-edged sword: teachers were dying of AIDS and infected parents could no longer afford to send their children to school. Ahead of the government response came the community response of setting up community schools. This response has been so strong that not only is the Government now assisting the community schools (e.g. with teacher training and learning materials), but these schools look set to replace formal schools as the norm. In view of this, the Government started working to ensure that children in community schools receive the same quality of education as those in government schools, though interestingly enough, some community schools have been found to provide a higher quality of education than government schools provide. Last year the Government abolished school fees, but most schools have since introduced alternative fee systems because they have to be able to raise funds to maintain and expand their activities, or to survive at all. Most now have, for example, a 'fence fee', which parents have to pay, thus abolishing the government fee system hasn't really helped poverty-stricken parents. I must also note that when the Government passed a law that children don't have to wear a school uniform – in response to an NGO lobby for such a law – the communities objected! They want children to wear a uniform. The upshot is that each community has a choice in this regard.

Question: Zambia's efforts to promote community self-reliance must be commended. Do these extend to the domestic level? Has Zambia explored the possibility that providing home-based care to families could promote a culture of dependency at the end of the day?
Answer: We addressed the dependency issue very early in the response, hence the focus on communities mobilising their own resources and distributing these among the households. At household level the approach is the same; families are given business and caring skills so they can cope on their own, and the community assists where they can't. In some parts of Zambia income-generating activities run as businesses per se have not worked very well because the efforts tended to sway towards running

the business instead of achieving the goal that the community/organisation set out to achieve. We are still battling with income-generating and micro-financing questions; we haven't found all the answers. People who have never run a business cannot be expected to succeed overnight. Again this is a process you have to work through.

Question: How do you ensure that caregivers who receive the assistance meant for OVC do not use it for other purposes?
Answer: One thing we have learnt is that when you direct assistance to an orphan in a household, you create imbalances in that household. It is better to direct the assistance to the whole household. This is because the presence of the orphan may be making the whole household more vulnerable and the orphan is targeted if there are problems, or you'll find the orphan saying, "But this is my bag of meal!" ... . The other option is to direct the assistance to the community and let the community decide who to give it to. In Zambia we basically discourage giving support to OVC directly.

Question: Are local interventions such as the CARE counselling centres set up in Zambia in the early 1990s still in place? Their focus was on living positively with HIV/AIDS, voluntary counselling and voluntary testing.
Answer: CARE counselling is ongoing, and the centres still offer counselling training courses. They have made great strides in community outreach in terms of home-based counselling programmes, and they are still the leaders in finding solutions to problems cropping up in the psychosocial care programme in Zambia.

Question: Is the Zambian Government able to afford special treatment for OVC financially?
Answer: As I have said, OVC support is left very much to communities, and we have no direct government-funded OVC support programme. Communities decide who the vulnerable children are, and they assess very accurately who needs what support. A child whose mother has died is likely to receive psychosocial, nurturing and nutritional support. Vulnerability is what counts, not orphanhood, since an orphan may not be vulnerable, and the child of a millionaire can be vulnerable.

Comment: It is a concern that the Zambian or any SADC government has to be pressurised for a law or policy on OVC. If we don't protect children, we might as well stop talking about education or health or anything else since the children of today are the adults of tomorrow.
Response: I hope my presentation conveyed that we did things back to front in Zambia, but we are now regrouping and realigning, and hopefully now that we have a National OVC Steering Committee, which was formed about two months ago, we will have our policy. It is not always a bad thing to delay policy development, however, because you do need time to assess exactly what is happening on the ground so the policy will really address what it has to. It can thus be advantageous to delay policy. At the "Eastern and Southern Africa Regional Workshop on OVC" in Lusaka in 2000 the SADC countries agreed that they must move forward as a region since what happens in one country affects what happens in the others. If we don't move concertedly together it will make little difference what each country does unilaterally. On Lusaka's streets today we find children from the DRC, from Zimbabwe, from Burundi ...; this illustrates the point. The challenges identified at the regional conference in 2000 are indeed being taken up by the SADC countries. We also have to start centres of exellence in the region, and SADC should have a resource base that we can all tap into. Nothing happens in isolation. The countries have moved at different paces, but we can learn from those that have moved furthest. I appreciate this comment because this is a very important issue.

Ms Coetzee-Masabane noted that this presentation and discussion had raised very many important issues that should be taken to the working group sessions. She thanked Ms Kapwepwe for her valuable and "very sobering" input.

PANEL DISCUSSION – Setting the Stage

Session chairperson: Ms Batseba Katjiuongua,
Director of Developmental Social Welfare Services, MOHSS

Ms Katjiuongua explained that the panellists would speak briefly on the work of their respective organisations, focusing on their future plans for addressing the OVC situation. The questions posed on the panel presentations are recorded on pp.56-59.

From left: Abner Xoagub, speaker on the National AIDS Coordination Programme; Selma Shejavali, speaker on programmes of the Council of Churches in Namibia (CCN); session chairperson Batseba Katjiuongua; Petronella Coetzee-Masabane of the DDSWS, speaker on critical challenges and critical actions around OVC in Namibia; and (inset) Emma Tuahepa-Kamapoa, speaker on the wok of NANASO.

From left: Lavinia Shikongo, speaker on future UNICEF support for OVC in Namibia; Mulenga Kapwepwe, speaker on the OVC situation in SADC countries; Adelheid Butkus-Ndazapo, speaker on work of the MWACW's Division of Early Childhood Development; and Claudia Tjikuua, speaker on MBESC efforts.

Children Living in a World with HIV/AIDS

Speaker: Mr Abner Xoagub, Manager of the National AIDS Coordination Programme (NACOP) in the MOHSS

Since NACOP was launched about 10 years ago, we have focused mainly on HIV/AIDS education and awareness programmes, and on setting up infrastructures and support services around the country so that we are better positioned to deal with the general impact of AIDS. In the last five years we have seen the number of children affected by and infected with HIV/AIDS increasing rapidly, so we are now intensifying our focus on children. The National Strategic Plan on HIV/AIDS launched by President Nujoma on 24 March 1999 obliges all sectors to address HIV/AIDS. At that time the responsibility for child welfare fell to the MOHSS alone, but now it will be shared by the MWACW, and NACOP will support the efforts of both sectors to deal with the OVC issue.

BACKGROUND

Current and future objectives: NACOP's general objectives are and will continue to be to provide information on the social benefits, services and assistance currently available for Namibians infected with and affected by HIV/AIDS, and to ensure that the points of access to such benefits and services under the Social Services Act and Social Security Act are known to all Namibians. At present most people are still unaware that these services are available. Our more specific objectives are and will be:

- to provide information about eligibility requirements and access to the social services, benefits and support available for the general public, people living with HIV/AIDS, children, families as well as health workers – through the mass media, CBOs, the Regional Councils and Regional AIDS Committees;
- to provide care and support to the affected individuals based on their means; and
- to engage communities in caring for and supporting those affected, placing special emphasis on people with disabilities, women and orphans.

Current and future actions: The relevant sectors are expected to participate in public debate through their regional structures; to establish functional counselling and support services; and to budget for activities, grants and resources for those infected with and affected by HIV/AIDS.

Current and future target groups: The specific target groups of the social services and child welfare sectors are and will continue to be the general public, children, people living with HIV/AIDS, their caregivers, the families affected, health workers, churches, insurance companies, the private sector generally, social welfare organisations, NGOs and CBOs.

Current and future key actors: The MOHSS, the MWACW, the Social Security Commission, national and international partners and organisations dealing with children, women and social welfare are and will continue to be the key actors.

NACOP's future work for children/OVC: NACOP will focus first on sensitising people to the rights of children as the primary strategy for enhancing prevention and reducing the impact of HIV/AIDS on children. Children have a right to survival, protection and development, and these rights have to be protected from the impact of HIV/AIDS. Furthermore they have a right to protection from discrimination and exploitation. Children are not vulnerable to the disease only because their parents may die of it, but also because some children are sexually exploited and thereby infected with HIV. They also have a right of access to health and social services on an equal basis, i.e. irrespective of their HIV status or that of any of their family members. Children have a right to sound and effective HIV/AIDS prevention and impact-reduction programmes to eliminate risk factors among them. Children's rights are human rights, so protecting children's rights entails promoting human rights for all.

SLIDE 1: Legal and policy framework:

Non-compliance with legal and policy mechanisms is a major barrier to effective and coordinated action. The National Strategic Plan on HIV/AIDS (MTP II) should be implemented by all sectors as a matter of urgency.

Mr Xoagub showed the following slides very briefly while providing the background information, i.e. without giving any commentary, but just to give the participants an idea of the main issues, learnings to date, needs and future plans that form the basis of the work to be done by NACOP – in conjunction with the other stakeholders – in support of OVC.

SLIDE 2: Database of organisations working with and for children:
A comprehensive database would facilitate and greatly improve communication and cooperation among the partners.

SLIDE 3: Networks and coordination mechanisms:
The advantages of a network of organisations working with and/or for OVC are obvious. A generic model of how a network can operate should be developed and training provided for potential partners throughout Namibia on how to initiate, construct, manage and sustain a network.

SLIDE 4: Poverty:
HIV/AIDS precipitates family poverty. An appreciation of this is fundamental to developing appropriate responses. Wherever possible, poverty alleviation programmes should work hand in hand with OVC programmes, and all should aim to provide basic necessities like food and clothing.

SLIDE 5: Identification of OVC:
This should be mandatory. A standardised form for registering OVC should be developed, which could in turn feed into the process of allocating grants and provide invaluable data for planning for the impact of increasing numbers of AIDS orphans.

SLIDE 6: Home-based care as the point of access:
The care of children affected/orphaned by AIDS is a natural extension of any home-based care programme for people with HIV/AIDS. Every home-based care programme should cater for affected/orphaned children as an integral programme component.

SLIDE 7: Holistic care and support within a comprehensive continuum:
'Care' and 'support' are the terms most used in the MTP II in considering children affected by HIV/AIDS. 'Holistic' care and support entails addressing the full range of human individual, family and community needs, i.e. physical, emotional, spiritual and social. In practice this would require health- and welfare-focused initiatives to consider expanding their models.

SLIDE 8: Planning for the future of children who will be orphaned:
The stigma associated with a positive HIV status very often results in silence about a parent's impending death, this being a barrier to planning for a child's future. Bereavement and family counselling should include discussion on a child's future. Whether by means of a 'Memory Book' or in a family conference setting, creating an appropriate time to talk about the future is of great benefit to both parents and children. Fostering within the extended family should be considered – through a multi-sectoral approach.

SLIDE 9: Supporting child caregivers:
Little has been done to prepare and support children who are caring for dying parents. Where there is no viable alternative caregiver, these children must be prepared for as well as supported in playing this role.

SLIDE 10: Promoting a rights-based approach:
Educating caregivers and children on children's rights will give children alternatives based on these rights. The best interests of the child must be a guiding principle in all programmes, and all training programmes should incorporate modules on children's rights. Strategies for ensuring effective participation of children and youth in all programmes should be implemented.

SLIDE 11: Support for affected children:
There is growing consensus that 'drop-in centres' catering for support groups, counselling, homework supervision, meals and so on for the children affected by HIV/AIDS would play a valuable role. CBOs should identify the specific needs of the affected children in their programmes and consider establishing such centres.

SLIDE 12: Community mobilisation:
There is global consensus that responses to HIV/AIDS must be situated in and owned by communities if they are to be effective, but in reality HIV/AIDS is impoverishing communities and unravelling families.

The starting point for mobilising communities to respond is to let each community identify its own concerns as well as what responses would be possible with existing internal resources. Thereafter there must be a process to decide on priority needs. Only at this point should any outside capacity or resources be added to enable a community to undertake its chosen activities.

SLIDE 13: Discrimination and stigmatisation associated with HIV/AIDS:
These still constitute significant barriers to effective service delivery. Projects have found that not being AIDS-specific, i.e. providing home-based care to people having any fatal disease and supporting all orphans, helps to minimise this barrier.

SLIDE 14: Capacity-building:
Projects whose primary aim has thus far been service delivery are increasingly being drawn into providing training, many to the extent that their focus is changing. It is necessary to identify who requires training at national, regional and local/community level, and to share training resources.

SLIDE 15: Grants:
Nationwide awareness-raising programmes are needed to educate the general public on the available grants and benefits for OVC. The grant application process must be simplified because presently it is long and complicated, especially where birth certificates and other IDs are needed.

SLIDE 16: Research:
It is necessary to generate a research agenda because there are multiple areas in which research is required to provide data to guide the implementation of a national strategy for OVC.

OVC in Namibia: Some Critical Challenges and Critical Actions

Speaker: Ms Petronella Coetzee-Masabane,
Deputy Director of Developmental Social
Welfare Services, MOHSS

I will speak on some of the critical challenges we are facing in respect of OVC in Namibia, and some critical actions that we would need to take to meet each challenge. By no means are these prescriptive, but as a government body responsible for social welfare, the MOHSS believes that these challenges and actions should be placed on the national agenda.

Ms Coetzee-Masabane displayed the table opposite on the overhead projector and proceeded to elaborate briefly on each critical challenge and set of associated actions.

CRITICAL CHALLENGES	CRITICAL ACTIONS
1. Leadership agenda on OVC	1. Reach consensus on policy framework. 2. Resources in accordance with needs and extent. 3. Strengthen partnership. 4. Advocacy for integrated inclusive approach to planning and service delivery. 5. Review legislation.
2. Better care and support to parent/family caregivers	1. Access to Early Childhood Development (ECD) Programme. 2. Access available material/resources information, identify gaps and establish an information dissemination mechanism. 3. Set up a database of service providers and distribute. 4. Expand teams of community mobilisers. 5. Avail home-based care kits to caregivers for their protection.
3. Expanding the number and quality of organisations	1. Strengthen coordinating structures at all levels. 2. Expand emerging support groups to under-served areas. 3. Advocate for organisations to expand activities to OVC. 4. Develop best practices, document them and disseminate.
4. Resources to base (welfare and economic/productive strengthening)	1. Expand income base, e.g. SMEs and micro-finance schemes. 2. Overhaul social assistance system to focus on childcare group. 3. Continue and expand participatory rural assessments (PRAs). 4. Provide material assistance to service providers, e.g. the ECD Programme, to encourage orphan care.
5. Expanding the role of schools and education systems	1. Widely distribute Learner/Parent/Caregiver Charter on Rights, e.g. waiving of school funds and boarding fees. 2. Implement policy on educationally marginalised children. 3. Establish extent and causes of dropout at primary schools. 4. Basic (vital) life skills.
6. Strengthening participation of children, families and communities	1. Simplify laws and policies and produce user-friendly booklets to inform on rights. 2. Establish integrated community service centres (one-stop) in under-served areas. 3. Participatory drafting of orphan-care strategy.

COMMENTARY

Leadership Agenda on OVC: This conference has already noted leadership as a critical challenge in dealing with OVC. We regard this as our top priority. One of the reasons you have been called here is to reach consensus on a policy framework. This forum provides an opportunity to start interacting and networking to form strong and lasting partnerships between organisations working in different sectors and different parts of the country. We cannot have each roleplayer acting on its own; we have to come together to ensure the integration of our respective services and a comprehensive response on OVC. Regarding legislation, we have to advocate for the enactment of long-outstanding bills such as the Child Care and Protection Bill, the Children's Status Bill, the Domestic Violence Bill and the Maintenance Bill.

Better care and support to parents/families/people living with HIV/AIDS and their caregivers: The

Early Childhood Develoment (ECD) Programme referred to is administered by the MWACW, and the MOHSS is one of the partners working on ECD. Many people complain that they do not have access to information on HIV/AIDS and support services, and it is crucial that we identify and fill the gaps. Every sector has to help ensure that people throughout the country can access this information. We have made an initial attempt to set up a database of service providers for needy children, as appears in the resources manual in the conference handout package. This list has to be updated from time to time because new services are established and expanded all the time while some are dying. Many of our clients say that they do not have access to supplies they need to care for family members, such as a rubber glove, protective sheeting or detergents, and due to this lack they are sometimes afraid to administer care, so we have to supply home-based care kits much more widely.

Expanding the number and quality of organisations: From constituency level up to national level we need to strengthen our structures. One primary objective of this conference is to find ways to reach all areas classified as 'hard to reach', some of which are still not receiving the services to which they are entitled. OVC must not be excluded from the agenda of any organisation serving families. In other words, every agenda of the sectors represented here must incorporate the OVC agenda. Regarding best practices, a lot of wonderful work is being done all over Namibia, but we have not made efforts to document best practices so that others can benefit too.

Resources to base (welfare and economic or productive strengthening): The DDSWS is responsible for administering the social assistance system and we are already in the process of overhauling it to focus on the childcare group. We have advanced very far, and it is now just a matter of getting the necessary legislation in place so that we can implement it. Regarding material assistance for service providers – we continuously complain about pre-schools, primary schools and ECD programmes not taking children in because they cannot pay – we can do a lot to provide some kind of incentive to make it possible for them to recover their loss in real money terms when they take in children who cannot afford the usual fees.

Expanding the role of schools and education systems: Many people still don't know about the Learner/Parent/Caregiver Charter on Rights that the MBESC has developed, which covers, among other things, school and hostel fee waivers, the waiver eligibility criteria and the application procedures. We have to ensure that this information is distributed very widely. We also have to fully implement our policy on educationally marginalised children. There is actually an education conference presently underway in Okahandja addressing this very topic. Regarding school dropout, while we are very proud of our primary school enrolment rates, we have to find out precisely why many children in fact drop out at primary level; we cannot merely assume that this is due to their not being able to pay school funds or buy a uniform.

Strengthen the participation of children, families and communities: Simplified or user-friendly information materials on children's rights are necessary to enable people to claim these rights. Regarding the proposed one-stop service centres, presently a number of ministries are planning to construct multi-purpose or community centres all over the country. This is unsustainable as well as inaccessible because it requires people to go from centre to centre to access different services. For a person who has no money for transport and who only needs to fetch a form to apply for a fee waiver, for example, this presents a serious problem. Our people would be better served if they could access all services under one roof. This conference is the start of the process of drafting an orphan care strategy.

In conclusion, a word about poverty: We all talk about how poverty impacts on everything we do, and we are all now aware that poverty is possibly the greatest barrier to effective OVC programming at both national and community level. Indeed poverty creates the challenge while weakening the response, but poverty is not the only cause of the crisis on our hands.

Current HIV/AIDS and OVC Activities of the Council of Churches in Namibia (CCN)

Speaker: Ms Selma Shejavali,
Programme Officer for HIV/AIDS and Violence Against Women and Children,
Council of Churches in Namibia (CCN)

Ms Shejavali was requested just a few minutes before the panel discussion to replace CCN General Secretary Rev. Kathindi, who was unable to be present at the time. Being unprepared, she spoke very briefly about the current activities of the CCN in relation to HIV/AIDS and OVC.

The CCN affiliates are churches with full membership – about 13 churches are full members – or associated membership, or observer status.

As "the voice of the voiceless" during the liberation struggle, the CCN took on the role normally played by government in educating and implementing programmes. The CCN is no longer an implementing body; today it is a facilitating organisation, and it facilitates the involvement of its members in programmes implemented by others on issues of concern of the day. We work in partnership with several ministries and organisations.

The HIV/AIDS epidemic is one of the CCN's major concerns. Though our members have been slow to react to calls to initiate programmes on HIV/AIDS for their congregants, some have started programmes and we hope that others will soon follow suit.

As a Lutheran Church congregant I share the concern that my fellow congregant Hon. Dr Amathila expressed in her opening speech regarding the slow response of our church, but I must note that all three Lutheran churches in Namibia – especially ELCIN and ELCRN[1] – are now responding positively and quickly, and all these churches have appointed pastors to work as full-time programme coordinators – Pastor Diergaardt – a participant here – being one of them. The three pastors are working very hard and the CCN is doing whatever it can to encourage their work. The United Reformed Church of Rev. Henry Platt – also a conference participant – intends to start a programme for orphans, and this too we will do everything possible to support.

The CCN facilitates the involvement of its members churches in educating people, and a duty of any church is to provide Christian and social counselling, so counselling will be emphasised in future plans of the CCN.

The CCN also wants to focus on cultural values because Namibian cultures have very good values that could be built upon to help people. Community unity is one cultural value to pick up on in relation to OVC: Namibians are the children of their parents and of their communities.

The CCN wants to see all of its members becoming as fully involved as the Catholic Church has been in combating HIV/AIDS and caring for the people affected, and we will intensify our calls to this end.

The CCN stands ready to help implement the recommendations of this conference and those of all Namibia's previous forums on HIV/AIDS. These recommendations must not be allowed to remain mere theories and plans on paper, and we look forward to our continued work together in transforming them all into reality. I thank you.

[1] The Evangelical Lutheran Church in Namibia (ELCIN) and the Evangelical Lutheran Church in the Republic of Namibia (ELCRN). Ms Shejavali did not go into the differences between these churches.

The Work of the Namibian National AIDS Service Organisation (NANASO)

Speaker: Ms Emma Tuahepa-Kamapoha,
NANASO Coordinator

I will speak very briefly on the work and some future plans of NANASO.

NANASO is an umbrella and networking organisation for 38 NGOs working around HIV/AIDS in Namibia. Like the CCN, NANASO is not an implementing body, so it does not have its own direct OVC programme, but we will do everything possible to encourage and support our affiliates in their work for OVC.

Very few NANASO affiliates are dealing with OVC at present. As you all know, the Catholic affiliates are heavily involved in work for OVC, but considering the range and scope of the problems of OVC, it is obviously not possible for these organisations to deal effectively with OVC alone, so NANASO will now request all its affiliates to incorporate OVC-related initiatives into their HIV/AIDS programmes.

NANASO is also looking at launching a responsive programme, as an umbrella NGO, for all vulnerable children, which should be based on proper research undertaken by the relevant partners.

NANASO particularly wants to see the affiliated rural CBOs dealing with the OVC problem in their own communities, and will encourage the well-established affiliates to complement the rural CBO efforts. In fact a big problem for NANASO in recent years has been a tendency among the well-established NGOs or CBOs to start competing with newly established ones. The well-established NGOs and CBOs should rather be assisting the new ones with proposal writing, management and other such tasks and activities.

NANASO agrees with the MOHSS that institutional care for OVC should be the last resort, and we will encourage our affiliates to see to it that OVC are taken in by families in their respective communities, and that the fostering families receive support from the affiliates' donor funds.

NANASO will now start advocating around OVC issues and disseminating information to all our affiliates on the services available for OVC. I thank you.

The Early Childhood Development Programme and OVC in Namibia

Speaker: Ms Adelheid Butkus-Ndazapo,
National Coordinator of Early Childhood Development (ECD),
Ministry of Women Affairs and Child Welfare

The Division of Early Childhood Development within the MWACW's Directorate of Community Development has been following the situation of orphans since the time that the national Early Childhood Development (ECD) Programme was transferred from the Ministry of Regional and Local Government and Housing (MRLGH) to the then newly established MWACW. With financial assistance from UNICEF, the MRLGH had initiated a pilot orphan-care programme in two regions, namely Omusati and Ohangwena, to address the fact that HIV/AIDS was contributing to a dramatic rise in orphan numbers in Namibia.

The communities in the pilot regions were found to have different strategies to assist OVC. In many cases OVC care is transferred to the extended family,

and there are quite a few fostering families and community-caring initiatives and institutions to care for those not taken in by their extended family. However, all these mechanisms are insufficient. From an emotional, social and moral standpoint, the most serious problem in the two pilot regions is the existence of child-headed households and so-called 'non-visible orphans' (children who are not registered and who only the local community knows to be orphans).

In Omusati we have so far registered 1 200 orphans, and 110 ECD centres are caring for them free of charge, with incentives such as crayons and paints provided through UNICEF. Children who are too young (i.e. 0-3) to be located at the ECD centres are cared for by six community volunteers who visit homes to help OVC in various ways. In Ohangwena 203 orphans have been registered so far, 76 ECD centres are caring for them and the very young are in the care of extended families.

The MWACW does not aim to monitor children affected by HIV/AIDS, but rather to ascertain the total number of OVC in the country so that it can recommend ways and means to deal more efficiently with the crisis posed by their growing numbers. Namibia is faced with potentially fatal diseases other than HIV/AIDS, for example malaria and TB, and coupled with social hardships such as unemployment, malnutrition and inadequate health care, these will add to the number of children in difficult circumstances. The ECD Division has focused mostly on the 0-6 age group, and primarily on those served by ECD institutions, but MWACW programmes have to target children in all age groups (i.e. 0-21). This is a new task for a relatively new ministry, and the MWACW is still in the process of creating adequate organisational structures to fulfil it. The MOHSS caters for children of all ages, and the two ministries have to devise new ways to cooperate and coordinate efforts on their common ground. The MWACW is aware that its indicators are still very limited, but we intend to conduct a survey to accurately assess the status of OVC. We also plan to disseminate information to potential donors and role- players in the hope of bringing OVC under the care of society at large and making them the objects of true social solidarity and caring. Thank you.

Education for OVC: Achievements of and Challenges for the MBESC

Speaker: Ms Claudia Tjikuua,
Chief Education Officer and Chairperson of the HIV/AIDS Committee of the Ministry of Basic Education, Sport and Culture (MBESC)

I will speak about the challenges facing the MBESC in respect of OVC and what has been done so far to meet them.

The complexity of the education arena and the challenges for those involved in education at all levels cannot be underestimated. This was the case even in the absence of HIV/AIDS, but with the epidemic the challenges have become insurmountable.

The four main objectives of the MBESC in seeking to provide "Education for All" are: access; quality; equality; and democracy. The MBESC vision has always been to increase school enrolment to 100%, and to decrease dropout rates especially at primary level. To date the following has been done to achieve these constitutional obligations: In the mid 1990s, in view of present social evils and past political disparities that affect/ed so many, the MBESC set up the Intersectoral Task Force on Educationally Marginalised Children with the aim of increasing access to schooling for all children excluded. A policy on educationally marginalised children was then developed and is now being implemented. This policy covers AIDS orphans as well. A charter for primary and secondary education has been developed, which outlines what every child should expect from the MBESC. Guidelines and press releases have been produced to inform people of the right to exemption from school development funds and hostel fees. A school-feeding programme is being run in some schools, and school counselling

support groups have been set up.

Despite all this, the MBESC is unsure if the children really in need of these services are being reached. A place in school and policies in place do not mean that a child gains the maximum benefits from schooling. Children need many forms of support, and if a child has no parent, all stakeholders are called upon to demand the services meant to assist them and to complement the efforts of schools to reach them. The MBESC is now considering expanding and strengthening these programmes because, for example, teachers and education officers need specialised training to counsel children affected by HIV/AIDS, and referral units are needed in schools because counselling support groups do not suffice. Easy mechanisms for school fund exemptions are needed, and these must be impermeable to abuse so that neither OVC nor schools find themselves lacking. The curriculum must be reviewed so it addresses HIV/AIDS issues like prevention, living positively with HIV/AIDS and caring for the sick. The MBESC can achieve all this only with good mechanisms for coordinating and networking with the other stakeholders, hence the MBESC is present at this conference. Thank you.

The OVC Situation in SADC Countries

Speaker: Ms Mulenga Kapwepwe,
OVC Consultant, Zambia

My task is to give you a brief overview of the OVC situation throughout the SADC region, but also in other African countries.

HIV/AIDS and poverty are the two main factors leading to orphanhood and vulnerability among children in all 12 SADC countries. About a third of all people in SADC countries are socially deprived. Angola has the highest poverty level and Mauritius the lowest. Human poverty increased in Zambia, Zimbabwe and Botswana between 1995 and 1998.

The Democratic Republic of Congo (DRC) has the biggest population at 49,1 million, and Swaziland has the smallest at 1 million. Angola, Zimbabwe, Malawi, Zambia and Mozambique all have 10-20 million people, while Lesotho, Namibia, Botswana, Mauritius and Swaziland all have 1-2 million.

Botswana has the highest HIV prevalence (in the world) among people aged 15-49 years, with 1 in 3 adults now HIV-positive. Botswana, Lesotho, Swaziland and Zimbabwe are all above the 20% prevalence mark; Zambia, South Africa and Namibia are hovering around the 19-20% mark; Mozambique and Malawi are at the 14-15% mark; Mauritius, Tanzania, the DRC, Angola and Uganda are below the 10% mark. Overall, life expectancy has dropped by about 6 years, and by at least 12 years in Zimbabwe, so a child born there today has a life expectancy of about 2,6 years less than a child born there before 1990.

Tanzania now has the highest number of orphans at 1,1 million, followed by Zimbabwe with 900 000, the DRC with 680 000, Zambia with 650 000, South Africa with 400 000, Mozambique with 310 000, Malawi with 300 000, and Namibia, Botswana, Angola, Swaziland and Lesotho with under 100 000.

The region is thus in a crisis economically and because of the HIV/AIDS epidemic. I am pleased to be able to report that some of the challenges on OVC articulated at the "Eastern and Southern Africa Regional Workshop on Orphans and Other Vulnerable Children" held in Lusaka, Zambia, on 5-8 November 2000 are being actively pursued in many countries, as you are doing in Namibia. The challenges agreed upon were as follows.

Placing the OVC issue on the leadership agenda: Much advocacy and lobbying is needed at national level in all SADC countries to give the OVC issue national prominence in all the countries. An OVC Desk at SADC level has been proposed. Some countries have drawn up advocacy plans, many are tackling OVC policy formulation (e.g. Rwanda, Burundi and Zambia), some have formed OVC action forums (e.g. Kenya and Zambia), and many countries which realised in Lusaka that they had not undertaken an in-depth OVC situation analysis and

thus did not have a clear picture of the situation resolved to go back and do this (e.g. Namibia, Zambia, Malawi, Tanzania, Burundi, Mozambique and Ethiopia).

Better care for families and caregivers: It was realised that proper care for families, parents or caregivers would prolong life and delay the onset of orphanhood – at least – but many countries still had to start inventorying what was happening on the ground in terms of care practices and programmes before they could enhance their care services. Some countries needed to start developing strategies and tool kits for home-based care, and others needed to enhance what they had. Burundi and South Africa felt that they had to actively pursue micro-finance activities to support people economically and thereby reduce vulnerability at community and household levels. Namibia, South Africa, and many other countries realised that they had to improve the legal environment for children, especially by amending outdated legislation like a Juvenile Act, Foster Care Act or Child Adoption Act. Some of these laws had not been revised for up to 30 years.

Expanding the number and quality of OVC support organisations: Much has been done on the ground in many countries, but many realised that they didn't know the profiles and coverage of these organisations, so they first had to do mapping and registration exercises to gauge who is doing what, and inventorying the capacity, coverage, locality, focus, quality and quantity of the organisations working on the ground. South Africa and Ethiopia were particularly emphatic about strengthening and providing opportunities for networking for their organisations. Many SADC countries are at the stage where they feel they have to start tackling the standards or quality of OVC care, whether in institutions or in NGOs involved in OVC programming. Some countries, like South Africa, are developing care policies.

Resources to base: The problem of getting resources down to the ground, meaning to the beneficiaries, or the children, surfaced again. There are countries where funds get stuck in the bureaucratic chain or tied up with bureaucratic ribbons or overheads and so forth, and most countries felt they were struggling to get resources to base. Uganda, Tanzania and Mozambique went back to look at resource distribution and transfer at community and district levels to see how they could realign their district structures for filtering resources to base. In countries affected by conflict, like Rwanda, funds and social safety nets were in place, but the focus was on child refugees or victims of conflict, so some of these are being restructured to cover OVC too. In other words, some countries are readjusting their national response to the impact of war on children to make it a response on 'the OVC problem'.

Expanding the role of schools and education systems: Some countries had to review their school curriculums, others had to restructure their entire school system. Zambia's system, for one, doesn't catch all the children, and at certain levels children are being thrown out of the system. We have to look at this because it's creating an even bigger problem. We also looked at the issue of disseminating OVC policy to education authorities and teachers because there was a gap between this policy and the education system, despite this system being a safety net. Kenya and Uganda emphasised their need to start orienting teachers on the problems of OVC and equipping them with psychosocial counselling skills. Namibia, South Africa, Swaziland and Burundi felt it was important to introduce life skills training. Kenya wants very much to be able to deliver health services through schools.

Strengthening child, family and community participation in OVC programme development: Most countries felt this would be a good way to bolster the solutions to the problems, so all the countries are now raising awareness on all kinds of human rights to enable people to debate more ably in seeking solutions.

There was agreement in Lusaka that what happens in one country in the region affects what happens in others, so the region must act as a region in response to OVC. Namibia is taking a serious lead by placing this issue on the agenda of the MOHSS.

Future UNICEF Support for OVC Programmes in Namibia

Speaker: Ms Lavinia Shikongo,
Information and Child Rights Officer, UNICEF

I will briefly touch on what UNICEF Nambia has done in the past, and then focus on our future plans.

UNICEF's mandate is to support governments and other partners in ensuring that the Convention on the Rights of the Child (CRC) is implemented, and that children's rights are protected and fulfilled. UNICEF has been in Namibia since independence in 1990, and has collaborated on various programmes with the Government and NGOs, mainly focusing on children's rights. As Minister Amathila indicated in her speech this morning, the Government, UNICEF and other partners are in the process of developing a new country programme for 2002-2005.

This programme will address two cross-cutting issues, namely HIV/AIDS and disparity reduction. How this programme applies to our topic here is that it will target specific groups of OVC: orphans, educationally marginalised children (mainly San and Ovahimba), abused children and children in conflict with the law. An Early Childhood Development component will cover OVC in the 0-6 age group.

One broad programme aim is to increase the number of orphans having access to basic services like education, health – especially for orphans infected with HIV – and psychosocial care. Three examples of specific programme objectives are to ensure:

- that 80% of all children conflicting with the law in urban areas and at least 60% of those in rural areas are treated in accordance with the Juvenile Justice Act – a bill has been drafted;
- that 60% of all OVC have access to basic education, medical care, counselling and protection from loss of property; and
- that at least 50% of all educationally marginalised children have completed their primary education by the end of 2005.

The programme will also look at the issue of inheritance rights and the preparations that ailing parents should make in this regard. We also have to look at communicating with the communities, families and individuals most in need of services, to ensure that they know exactly what is available. This will entail various forms of communication, but in the first place we have to have information to give them, so we will need to do research on a continuous basis. To strengthen communities and families, we need to provide skills as well as services to children, caregivers and others, and ensure that government extension workers – by which I also mean social workers – are facilitating the trickling down of services from national level to community level.

On the issue of protecting women and children from abuse, the programme will look at increasing the number of Women and Child Protection Units (WCPUs – resorting under NAMPOL). There are now 9 WCPUs in various regions – we are ahead of schedule as this is more units than we anticipated having at this stage – but Namibia has 13 regions and a very dispersed population, and some areas are still not being reached by the WCPUs, so we need more WCPUs, or any kind of protection service that will reach those areas. A mid-term review undertaken by the Government, UNICEF and other partners found huge disparities between urban and rural areas in that only where there are government structures are there protection services. We have to close this gap, especially since people in the rural areas may need these services most. We also have to deal with the problem of women and children being raped and thereby infected with HIV. We will try to ensure that people who come to the WCPUs, police stations or other institutions to report being raped have access to medication within 72 hours of the rape to eliminate the risk of HIV infection. We will also need to strengthen the WCPU managements.

The programme will address the need for closer collaboration between the partners, and the need for better coordination of services so as to ensure that they are delivered effectively and that there is no duplication.

Regarding juvenile justice, we will look at ways to ensure that children in conflict with the law are treated in accordance with international legal instruments. These require, for example, that children arrested must never be incarcerated in cells together with adults; that they appear in court as soon as possible after arrest (within 48 hours according to Namibian law); that wherever possible

they are diverted from formal legal procedures; and that there is follow-up to help ensure that the environment in which children live is not conducive to their committing further crimes.

The programme will also have a youth or adolescent HIV-prevention component to give young people the information and skills they need to avoid being infected, and to create an enabling environment within communities for young people to access information, skills and services easily. It is very important that we link youth programmes to OVC since young people are increasingly becoming responsible for the care of orphan siblings due to the high rate of parental death from AIDS.

We also need to continue advocating for law reform, and see to it that the draft laws pertaining to children are passed [see p.47 for examples of these]. We need such laws and policies to ensure that our safety nets really do catch all the people who need them most. At the moment some services are being provided because people want to provide them rather than because they are mandated or obliged by law to do so. Having more legislation in place will thus ensure better protection.

In conclusion, we need to keep monitoring and evaluating our programmes to ensure that we are achieving what we want to achieve and impacting on those we want to impact upon most. Thank you.

While speaking Ms Shikongo displayed the following slides conveying the general approach of the Child Welfare and Social Service Sector – just as background information.

NAME OF SECTOR: CHILD WELFARE AND SOCIAL SERVICES

General objectives:
To provide information about social benefits, services and assistance available for those affected by and infected with HIV/AIDS, and to ensure access to such benefits and services under the Social Services Act and Social Security Act.

Specific objectives:
- To provide information on social services, benefits and support available – to the general public, people living with AIDS, children, families and health workers – and on eligibility requirements for access to these.
- To provide care and support to people infected with HIV/AIDS and those in need.

Actions to be taken
- Inform the general public on eligibility requirements through the IEC, mass media, CBOs and regional councils.
- Promote among and engage communities in the caring and support of those infected with and affected by HIV/AIDS, with special emphasis on people with disabilities, women and orphans.
- Participate in public debates through regional structures.
- Establish functional counselling and support services.
- Budget for activities, grants and resources for those affected by and infected with HIV/AIDS.

Target population
The general public, children, people living with HIV/AIDS, their caregivers, families, health workers, churches, insurance companies, private sector and social welfare organisations, and NGOs/CBOs.

Key actors
Ministry of Health and Social Services, Ministry of Women Affairs and Child Welfare, Social Security Commission and national and international child and social welfare organisations.

QUESTIONS POSED ON THE PANEL PRESENTATIONS

Question: I direct my question to the Deputy Director of Developmental Social Welfare Services. Many communities have no medical doctors to care for people living with HIV/AIDS, but only traditional healers, and their methods have been condemned by the Prime Minister and Minister of Health and Social Services. The traditional healer sector does not seem to be included anywhere in the national response to HIV/AIDS. How will they fit in, if at all?

Answer: The Prime Minister and Minister of Health and Social Services were targeting the individual traditional healers who have been abusing their power over their patients [see p.13] – as some conventional western medical doctors do. The MOHSS has in fact made provision for the establishment of a Council of Traditional Healers, so that we can determine exactly what the relationship between modern medicine and traditional medicine should be. We have been trying to do this since 1990, and though we have not succeeded yet, I can confidently state that this is not due to a lack of will or effort on the MOHSS's part. There are some MOHSS officials constantly negotiating with traditional healers, and in the MOHSS and the Government as a whole there is an understanding and appreciation of their role. We would never deny their role. The Government very much wants to find ways for traditional and conventional medical doctors to work together. Of course there would be some boundaries, for example traditional healers would probably not be allowed into a theatre where surgeons are operating, nor would traditional healers allow medical doctors to be present in their own consultations. But there is certainly scope for them to work together and the MOHSS has never denied this and is working on it.

Question: It seems we all agree that reaching out to orphans through centres is not the right approach. But if extended family members care for them, how exactly will the MOHSS and other ministries go about mobilising the necessary financial and other resources to enable them to care for the children properly? Also, will there be counselling services for the extended family caregivers?

Answer (NACOP and DDSWS): Namibia has legal mechanisms in place and these must be implemented. At this point we have a problem with compliance in implementing them, which we have to address, and we still need to pass key draft legislation relating to children, but we already have the necessary mechanisms to facilitate resource mobilisation and service provision. Most of the resources required for OVC programmes will be mobilised through the National Planning Commission in partnership with one or two key ministries – probably the MOHSS and MWACW. The Social Security Commission and Pension Fund will also play a role since they pay out funds when parents die, and these can be used to cover school fees and sustain the children. But most important is that our approach is holistic, which entails addressing the physical, emotional and spiritual needs of OVC, so we require the services of all institutions that can meet each kind of need. Traditional and community leaders, churches and all kinds of organisations can play a role, not only governmental bodies. Just stopping discrimination against people with HIV/AIDS will make the task manageable, and everyone can help in this respect. The affected families themselves have a very important role to play. We have to encourage ailing parents to make provision for the proper care of their children by drawing up a will, appointing a guardian, setting rules about education, etc., and also preparing the children themselves. All parents should do this, not only those living with HIV/AIDS. The MOHSS can certainly make provision for counselling extended family caregivers who need this support. We have trained many counsellors, who are now working in hospitals and clinics around the country and who also go out with our primary healthcare teams to visit communities, and many NGOs also have trained counsellors. There are many forms of psychosocial support that we will be able to provide, even if we are not yet properly geared up for these. By the end of this conference we will have a much clearer idea of strategies we can adopt. Right now we know that there are lots of services available in the country, but we don't all know what exactly they are and how to access them, so this conference is the starting point for gathering this information and coordinating efforts to bring the services to the people. Meanwhile, people needing to access services can ask their local social work office for direction, and we as service providers can use the resource manual in the conference handout package.

Comment : Although the OVC situation can be

considered an emergency situation, it has very long-term consequences. The Government is doing a lot to set up emergency structures in the relevant sectors, but I am concerned that this conference will duplicate those structures, and also that the support links for OVC will be broken once the emergency is deemed over and emergency structures fall away. I propose that one recommendation of this conference should be the setting up of a single strong and permanent central structure to ensure that the needs of OVC as a specific group are met over the long term.

Response (Ms Katjiuongua and Ms Coetzee-Masabane, DDSWS): This is an important proposal to consider, but it must be noted that we do have a medium-term plan of action in place already which incorporates all existing structures, so we will not duplicate structures here. The task of this conference is to devise a framework and specific action plans to guide the existing structures in implementing this medium-term plan. Setting up a new central structure now could actually complicate our work since skilled people serving in the existing structures would probably have to serve in the new structure too. On a separate but related issue, there seems to be some confusion about our target group: we are dealing not only with orphans, but with all vulnerable children as a single group. It is important to bear this in mind throughout the conference. Namibia is a small nation with limited resources, so we can't have a programme to address each and every kind of vulnerability. We need one national response on OVC, and we have to direct our resource pool to where the need is greatest among OVC.

Comment: Regarding state institutions from which resources will be drawn, please don't forget the Government Institutions Pension Fund (GIPF) which pays out pensions to patients, and the Motor Accident Insurance Fund which covers children who lose their parents in road accidents – even though the accident funds paid out to extended family members often don't reach the children!

Comment: In view of the unemployment rate in our country, it will surely be necessary for us to ascertain that people who take in OVC are employed and that they can really afford to care for them properly, especially if they already have their own children to care for.

Comment (Dr Cownie): Regarding education supply, a finding of studies that SIAPAC worked on in Mozambique and Swaziland was that due to HIV/AIDS, for every 100 school teachers that would normally be trained to ensure education for all, 125 have to be trained just to maintain current coverage. This means that just breaking even could entail a 25% increase in the actual cost of teacher training.

Response (Ms Tjikuua, MBESC): I deliberately left this issue out of my presentation so as not to preempt a big study that we plan to launch soon to determine the effects of HIV/AIDS on the education sector, which will tell us about supply and demand, quality of education, etc. We hope to hold a conference to discuss the study findings and what actions are needed.

Question (Dr Cownie): In Swaziland many older children wanted to know how they could access adult education classes as they had to care for younger siblings and could no longer cope with this task under the formal education system which requires them to stick to a rigid class attendance schedule. Are we seeing this trend in Namibia?

Answer (Ms Tjikuua, MBESC): We have not seen this here, but we must remember that Namibia is slightly behind the tide in terms of gauging the actual impacts of HIV/AIDS on the youth, so we may see this happening in the years to come. At this stage we are actually seeing precisely the opposite of the trend that Dr Cownie describes: many junior secondary learners who do not attain the points required to move to senior secondary level (i.e. Grades 11-12) leave the formal school system and enrol in the Namibian College of Open Learning (NAMCOL), and once they have acquired the extra points needed, they ask to re-enter the formal school system to complete their senior secondary education.

Question: Regarding the incentives for ECD centres, I feel strongly that feeding schemes for child-headed households particularly are necessary, and I wonder whether the relevant ministries have made any provision for such schemes at the centres.

Answer (Ms Butkus-Ndazapo, MWACW): We have asked UNICEF whether feeding schemes can be incorporated into the incentive package, but unfortunately UNICEF is not mandated to support feeding schemes. We approached the World Food Programme (WPF) for support last year, and it was provided, but only for one year. Rather than asking any other partners for food support, the MWACW decided to start income-generating activities (e.g. gardening projects) for the ECD centres. As well as

providing food for the centres, these projects will give parents opportunities to earn an income.

Question: What is the MBESC doing about pregnant girls who drop out of school, and has the "My Future, My Choice" programme run in schools had any impact on vulnerable youth in terms of preventing HIV/AIDS, STDs and alcohol abuse?
Answer (Ms Tjikuua, MBESC): Teenage pregnancy remains a major problem in schools and a major struggle for the education authorities. However, Cabinet has already passed some of the recommendations of a draft MBESC policy on teenage pregnancy, which are now being implemented. One of these is that pregnant girls must be allowed to stay in school for as long as possible, or for as long as their heath allows, but another is that they must not be allowed to return to school for one year after delivery because they should stay at home to care for the baby – unless there is sufficient proof that the parents of the girl (or of the boy who fathered the child) are able to care for the baby during its first year of life. Regarding the impact of "My Future, My Choice", as Minister Amathila noted, surveys have established that there has been no increase in the rate of HIV infection among young people in the last four years. We hope this is due to "My Future, My Choice" and other programmes implemented in our schools and communities.
Addition from Ms Shikongo, UNICEF: It must be borne in mind that behavioural change is a long process. Researchers say it takes 5-6 years to see change in behavioural patterns. On the issue of food support for ECD centres, I wish to clarify that UNICEF does not have its own programmes, but rather supports those of government and other partners, and we focus on sustainable programmes, i.e. those that the partners or communities can continue to run without further donor support. Also, UNICEF's funds come from other donors, and it is very rare for a donor to provide funding for very long periods, e.g. 10 years, so we are careful not to raise communities' hopes and expectations of ongoing support. On the contrary, they must be led to understand that they are expected to sustain the activities on their own.

Question: If an orphan is defined as a child whose mother has died, how will children be provided for if their father dies of HIV/AIDS and their mother is unemployed and therefore not eligible to an insurance payout?
Answer (Ms Katjiuongua, DDSWS): Just to reiterate the definition of an orphan as applied by this ministry: an orphan is a child under 18 years old whose mother or father or both have died. For some benefits, e.g. foster care grants for children found to be in need of care, the age may be extended to 21 if the child is still attending secondary school full time. In Namibia an orphan is not just a child 'in need of care' since an orphan may need support and protection, but not necessarily care. The resource manual in the conference handout package lists all services currently available for children in need, and as Minister Amathila noted this morning, we are looking at solutions to the insurance problems.

Question: Regarding medication for rape victims within 72 hours to prevent HIV infection, Ms Shikongo said this is given to women and children. What about men who are raped?
Answer (Ms Shikongo): What we have now are Women and Child Protection Units, not 'Men Protection Units', but in any case, I was referring to the GRN/UNICEF programme that will start next year, and this is a service we are planning to provide under that programme. We must still devise procedures for administering the medication, and the Government must still make it available to all units at all times, so this is a plan we hope to enforce as from next year. [Chairperson Ms Katjiuongua remarked that if any male participants were "feeling left out", they should "take cognisance of the fact that most sexual offences are committed by men".]
Addition from Ms Lwin, UNICEF: Where men are subjected to causes of HIV infection such as an infected needle prick in a hospital – an unlikely event – they will of course be treated. The medication will be available to both sexes, but circumstances will come into play.

Question: Ms Shikongo said that some of the services are being provided by people who are not really mandated or obliged to provide them. What is the mandate of the regional juvenile justice fora in terms of statutory law?
Answer (Ms Shikongo): At present Namibia has no national law that conforms with the CRC in terms of juvenile justice specifically, nor do we have any policy guidelines at this stage. But because Namibia is obliged to implement the CRC, partners at national level – coordinated by the DDSWS – asked the regions to put up structures for implementing a juvenile justice programme despite the absence of a law and policy to guide it, and the regions took up

the challenge and set up these fora. The Government meanwhile set about drafting a Juvenile Justice Bill, and established the Interministerial Committee on Juvenile Justice to oversee the programme implementation. The Prosecutor-General gave permission for the programme to be implemented, and NAMPOL sent out a circular to all police stations instructing them to treat juvenile offenders in accordance with international legal instruments, then started training police officers to do this. So in effect the juvenile justice fora are mandated by the Government to start implementing a system that will soon be regulated by statutory law.

Question (FHI consultant): This question is directed primarily to the speaker on the ECD Programme, but to anyone who registers OVC for any programme. Studies have shown that many AIDS orphans live in environments where they are very well cared for, and who are less vulnerable than many orphans whose parents died of other causes and who are living in precarious situations, or less vulnerable than needy children who are not orphans. Are you able to identify which children are the most needy or vulnerable? In other words, do you apply any criteria or do you have mechanisms to measure the extent of vulnerability, and if so, do benefits to centres or individuals differ accordingly? I know this is a loaded question.

Answer (Ms Butkus-Ndazapo, MWACW): We do not assess individual vulnerability when we register orphans, but the centre administrators do know the children's situations and regional programme administrators know what centres are most in need of government support.

Ms Coetzee-Masabane made a further announcement about the video being produced on the conference. So far very few people had approached the Prime Time Media cameraman for an interview on their organisation's work in the regions, so the cameraman had been instructed to approach people. It was noted that both the pre-conference video and this one on the conference would be very helpful to organisations busy drafting policies on HIV/AIDS and childcare, and Prime Time Media had offered to give each participating organisation a copy of each video. The participants were asked not to make these videos their personal property; they must be kept in the offices so that all staff have access to them. [See p.87 for a synopsis of the conference video.]

The participants singing "Bind Us!" – a song of praise well known to Namibians.

WORKING GROUP SESSIONS

(report-back to plenary)

Session chairperson: Ms Petronella Coetzee-Masabane,
Deputy Director of Developmental Social Welfare Services, MOHSS

Day two of the conference opened with a prayer led by Rev. Diergaardt of the Evangelical Lutheran Church in the Republic of Namibia (ELCRN), preceded by this message from Rev. Diergaardt:

Rev. Diergaardt

God calls on us to tend to the needs of needy children, who are sometimes forgotten children in Namibia and in the world, and we call on God to save precious lives. In the context of vulnerability, we realise that we are human. To be human means to be involved in the home, in the church and in society. As a Christian-oriented society, we are called to be a healing society; to support our brothers and sisters and our children affected by illnesses like HIV/AIDS. God calls on us to stand with all our vulnerable people; to love, accept and care for them. Now a moment of silence for those who have died of HIV/AIDS.

Ms Mulenga Kapwepwe's presentation on the OVC situation in Zambia followed this devotion. (For the sake of continuity this presentation and the questions posed on it are recorded in the section on Expert Presentations, pp.33-42.)

The working groups deliberated from 11am until the end of the day. The report-back session and discussion on the group work took up the whole of the third day, except for the final hour, which was reserved for forming a National Steering Committee on OVC.

Group registration: The group session topics were displayed outside the hall from the start of the conference, and the participants were asked to select the session to which they felt they could best contribute, and add their name to the appropriate registration list. There should be no more than 40 people per group. The delegates from larger delegations were asked to spread themselves among the groups so that their knowledge and experience could be shared more widely.

Group instructions: The group session topics and objectives reflected the conference objectives (see opposite). They were designed to enable the participants to debate information given to them, identify gaps, and devise one key strategy and recommendations for implementing it. These would be adopted by the conference – as amended by the plenary – and implemented by the National Steering Committee. Each group would have two or three facilitators to guide the discussion. So that language did not pose a barrier, participants preferring to speak in a language other than English were requested to inform their facilitators, who would ensure the presence of the necessary translators. The participants were asked to participate fully in the group sessions since the outcome of this conference would determine the future of OVC in Namibia. Each group had to democratically elect one person from Windhoek and one from the regions to serve on the committee. By the end of the day each group had to submit to the chairperson a write-up of its key strategy and four prioritised recommendations. The groups were assigned separate breakaway rooms at the conference venue.

OBJECTIVES SET FOR THE FIVE WORKING GROUP SESSIONS

These objectives are extracted verbatim (with minor space-saving edits) from the document given to the groups.

SESSION 1 (facilitated by CAA):
How can the local community support OVC?

- Share details of any existing community support to OVC.
- Map out a rural and urban community.
- Identify the types of support each community member could offer.
- Identify what resources would be required to sustain that support.
- Identify who would coordinate this response.
- Devise a key strategy and recommendations for its implementation.

SESSION 2 (facilitated by UNICEF):
Who are the key stakeholders and what role should they play?

- Identify the major international, national, regional and constituency stakeholders.
- Identify the role that each of these stakeholders should play.
- Map out the relationship between each of these stakeholders and identify gaps or duplication in these relationships.
- Develop terms of reference for each stakeholder.
- Identify who would coordinate the interface between all stakeholders.
- Devise a key strategy and recommendations for its implementation.

SESSION 3 (facilitated by the MWACW):
How can we ensure that the rights of OVC are protected?

- Group to be aware of all the international and local rights afforded to OVC.
- Group to be aware of who has the responsibility for implementing these rights.
- Identify whether these rights are being provided for in Namibia and the gaps.
- Devise a key strategy and recommendations for its implementation.

SESSION 4 (facilitated by FHI):
How can we use current prevention and care activities to support and promote OVC?

- Discuss the pros and cons of using established prevention and care activities to support and promote OVC.
- Map out all the current prevention and care activities provided to young people.
- Identify which of those activities already support and promote OVC, and any gaps.
- Identify which of those not already supporting OVC could be used.
- Devise a key strategy and recommendations for its implementation.

SESSION 5 (facilitated by the DDSWS):
How can we ensure long-term and effective social safety nets for our OVC?

- Identify what social safety nets are currently available to OVC.
- Identify the problems in accessing those safety nets.
- Identify the gaps in the safety nets.
- Determine the age group of OVC with special reference to access to education.
- Determine the age group of OVC with special reference to access to social assistance and inheritance.
- Devise a key strategy and recommendations for its implementation.

Below: The five groups in session, and report-back session chairperson Petronella Coetzee-Masabane.






The third day of the conference opened with the singing of "The Lord's Prayer" and "Thank You Jesus". The conference T-shirts were then distributed (see handouts p.87).

Before calling on the first group rapporteur, Ms Coetzee-Masabane acknowledged the hard work of the conference organisers who had spent most of the night typing up the group proposals so that all participants could have copies in writing by morning.

The groups reported back only on their key strategy and four prioritised recommendations, i.e. not on their actual discussion, so the group discussion summaries have been reproduced verbatim from the flip-charts or notes given to the report compiler – with a few minor edits made for layout purposes or due to space constraints. It must be noted that this record conveys the strategies and recommendations as amended by the plenary. There were very few amendments. Also, these transcriptions are arranged consecutively from Group 1 to 5, whereas the groups actually reported back in the reverse order, but only in one or two instances the reader may need to refer to a point under Group 4 or 5 to understand a point under Group 3, for example.

GROUP SESSION 1

How can the local community support OVC?

Rapporteur: Ms Francis van Rooi,
Special Projects Officer, Catholic AIDS Action (CAA)

FACILITATORS

Ms Francis van Rooi and Ms Caroline Thomas, Special Projects Officers, Catholic AIDS Action.

KEY STRATEGY

Develop a national comprehensive home-based family and orphan support programme.

RECOMMENDATIONS

1. Programmes based on voluntarism, involving entire communities and other stakeholders.
   - Standardised and systematic training.
   - Decide who should be responsible for this.
   - Monitoring and evaluation mechanisms to be put in place.

2. Develop a national register of OVC
   - Free (really free!) education and health care to be provided.
   - OVC to be identified by volunteers and other stakeholders, e.g. teachers.

3. Develop a national register of caregivers and foster parents (to be identified from grassroots level upwards)
   - The main purpose of this is to have people (readily) available in this capacity.
   - Volunteers can identify these persons.
   - A network of faith-based organisations (being at the heart of the community) to take responsibility for overseeing, monitoring, supporting and following up on caregivers after placements.

4. Establish an OVC Fund
   - The OVC Fund should be administered by a new body.
   - Social workers and the Master of the High Court are not recommended because their existing workloads would make it impossible for them to administer a fund with the potential for a 20-fold increase.

ADDITIONAL NOTEWORTHY POINTS IN THE REPORT-BACK

No doubt everyone present would be able to add at least one community support structure to those we identified [see next page]. We did not seek to identify every one of them. It was proposed in the group that the communities rather than government should take primary responsibility for implementing Rec. 1, but no decision was taken on this. Regarding Rec. 4, we felt that all taxpayers should contribute a small amount to this cause by way of a levy, and that additional funds should come from commercial banks, insurance companies and the like. By a "new body" to administer the OVC Fund, we mean not government as such.

SUMMARY OF GROUP DISCUSSION (verbatim transcription of flip-charts and notes)

Existing community support structures: MOHSS and DDSWS; CAA; SOS Children's Villages; the Red Cross; Michelle Mclean Children's Trust; many others.

Urban communities:

- have smaller families – often only a nucleus, so if one or both parents die, children are left vulnerable sooner;
- are less reliant on the extended family;
- have easier access to structured or formal assistance such as NGO and social welfare services, etc;
- have higher costs of living.

Rural communities:

- are more dependent on informal resources such as the extended family or neighbours;
- have access to land;
- get by with less money.

Are OVC survival and development rights provided for?

- The MOHSS provides for these, but not all OVC are catered for.
- OVC residing in hostels are catered for if the school headmaster has certified that they are children in need of care.

Gaps to fill:

1. Building trust with OVC – requires: (a) speaking their language; (b) spending time with them; (c) being culturally-sensitive.
2. Information about rights: (a) The MBESC should bring parents and children together in meetings to make their rights known to them. (b) Organisations should not work on their own in disseminating information. (c) Mobilisation around rights protection should be well coordinated.
3. Financial constraints: (a) Government stakeholders should review their budgets so as to cater for OVC. (b) The services of social workers should be expanded, i.e. decentralised.
4. NGOs in collaboration with community leaders should intervene to protect rights where necessary.
5. Law and policy: (a) Review legislation on foster care. (b) Revise the rules for adoption to ensure that extended family caregivers or OVC living with extended families are covered by insurance policies and pension and medical aid schemes. (c) Review laws on foster care and adoption to include pre-primary children. These now only provide for children aged 6-16. (d) Wills and other inheritance-related documentation should be verified by the police, and they should have a police stamp as proof of their validity. (e) Needy children must be exempted from paying school and hostel fees by law or formal policy.

PLENARY DISCUSSION ON GROUP 1 REPORT-BACK

Comment (Dr Anttila, HSSSP2 Coordinator): I see a discrepancy in that the question posed to Group 1 pertains to local support while the strategy pertains to a national programme. We have heard that in Zambia the communities are raising the funds and implementing the OVC programmes, with the Government supporting them. I personally would prefer a strategy along those lines. Also, with a national family support programme we would have to be careful not to lose anything of value in terms of cultural differences in our regions. Such a programme should not necessarily be run in exactly the same fashion in every district and community; this should rather depend on how each community wants to implement it.

Comments on funding for OVC: Banks and insurance companies normally contribute to causes like this by donating funds to NGOs, so they are already contributing, and taxpayers are already paying enough; it just depends on the political will of Parliament and others involved with budgeting to place the right emphasis on an issue. My point is that the sources of funding identified are in place already, and the problem is only that the values are insufficient to cover what they need to.

Responses: Namibia's NGO sector is small compared to its insurance sector, and the latter is not contributing enough in view of its large coffers. Taxpayers are already over-taxed. Please do not suggest that we be taxed even more. We should rather lobby Parliament to create an OVC fund within the national budget. We should convince our

law-makers to spend tax monies better – less on defence, cheaper government vehicles, etc.
Suggestion (Dr Steinitz, CAA): I would like to suggest another untapped source of funding. In many other countries in Africa and beyond, when you enter or leave the country you have to pay an airport tax or some kind of fee. We have been blessed in Namibia in this regard, but most of the people who would pay this fee are people who can afford to. Perhaps we could include among our suggestions that this could be a source of revenue for OVC.
Response: Airport taxes and levies would all just go to the Ministry of Finance. We have to lobby for funds to go to OVC.
Suggestion: Municipalities could add a N$5 levy for OVC to monthly bills for services.
Comment (Councillor Trepper, City of Windhoek): We charge only for services rendered, so we couldn't do this. However, we have a Department of Economic Development which makes provision for vulnerable children who need assistance, who can apply for it. I have some good news for the conference: Last year the City of Windhoek hosted the SADC Summit, HIV/AIDS being very high on the agenda. One recommendation on HIV/AIDS was a mayoral alliance. Last week our Mayor, Mr Shikongo, represented the City of Windhoek in Abidjan, where the City of Windhoek was honoured in being appointed to coordinate the HIV/AIDS programme for the whole of Africa. Because Windhoek is a small city, some other countries objected, but it was decided that Windhoek should remain the coordinating city and there should be a sub-office to help, which will work through Windhoek. Windhoek will therefore receive the grants to be distributed to all African countries. We are still formulating the policy, and I will strongly recommend that the OVC programme should benefit from these funds.
Response (Ms Coetzee-Masabane): Thank you very much! Please convey our heartfelt congratulations and pride to the Town Council and especially to our Mayor. We hope that you will include us in your committee working out the policy, budget, etc., so we can ensure that our issues are placed high on that agenda. On the issue of funding, we have all agreed that we need to ensure increased funding for OVC. If an OVC Fund is seen to be the solution, then it should be established, and we will raise the funds needed – whether through government, private sector or other kinds of contributions. We must also bear in mind that funds are often distributed inequitably – with a few NGOs and projects always benefiting a lot and those unknown to funders not benefiting at all. We must ensure that all the worthy projects being run in rural areas also benefit from any funds we secure. We also need to look at income-generating options to raise our own funds.

Comments on OVC register: It is better to work from the grassroots up than from national level down. Compilation of an OVC register should start at constituency level, progress to regional level and finally to national level. Policy-making and coordination can happen at national level, but implementation and monitoring should always happen at constituency and regional level, and OVC identification must happen at grassroots. The plenary agreed to amend the recommendation to reflect these views.

Comments on orphan IDS: In as much as we may all agree that a register of OVC would help us to plan and channel resources effectively, these children are community members who have been exposed to a lot of trauma, and IDs could promote stigmatisation and discrimination of them. All children should be treated equally. Though IDs would ensure free health care, education and other state services for the children concerned, there must be other ways to ensure their access to these services. Also, if communities are asked to identify the OVC, it may be counterproductive to have these IDs.

> The group was asked to elaborate on a clause on issuing orphan IDs, which was originally included under Rec. 2. After some discussion on this issue the plenary decided to remove the clause. The same concerns expressed in the plenary [see below] had been raised in the group discussion, but the group left the clause in to see if others felt the same and to let the plenary decide.

Due to space constraints here, the last two points made in this discussion are recorded on p.81.

GROUP SESSION 2

Who are the key stakeholders and what role should they play?

Rapporteur: Ms Lavinia Shikongo,
Information and Child Rights Officer, UNICEF

FACILITATORS

Ms Lavinia Shikongo, UNICEF Information and Child Rights Officer
Ms Mulenga Kapwepwe, OVC Consultant, Zambia
Ms Ngondi Ngatjeheue, NANASO Committee Member

KEY STRATEGY

Develop a plan of action to mobilise all stakeholders' input for a coordinated response on orphans and other vulnerable children.

RECOMMENDATIONS

1. Develop a policy on orphans and other vulnerable children by December 2002.
2. Simplify and reinforce the implementation of the school funds exemption policy by January 2002 and ensure access to quality education by January 2002.
3. Develop linkages where they do not exist and strengthen the existing linkages between communities (an inclusive term meaning all stakeholders) and government to ensure that orphans and other vulnerable children have access to services.
4. Ensure the active participation of the private sector in the National Steering Committee on OVC, including insurance companies.

ADDITIONAL NOTEWORTHY POINTS IN THE REPORT-BACK

The plan of action must specify who should do what, as well as times frames. The group's understanding was that the National Steering Committee on OVC to be formed here will take responsibility for Rec. 1, and that a year and a half will be enough time for both drafting and adopting the policy. On Rec. 2, we discussed education issues at length, and we must note that: (a) the school fund exemption policy is not known, and where it is known it is not being fully implemented; and (b) this is largely due to the long string of application procedures that people have to follow before exemption is actually granted. The procedures have to be simplified especially for people in rural areas, such as a grandmother caring for five children, who have great difficulty accessing the people they need to access to meet the requirements. The MBESC could consider mandating people closer at hand to grant exemptions. However, if the exemption policy is fully implemented, many schools may find themselves unable to provide quality education due to a lack of funds, so if school principals are asked to implement it, they must also be told how they can make up for the shortfall. If parents who are paying funds see the quality of education in a school dropping, they will take their children out of that school and their funds will go with them, making the whole situation even worse. The deadline of January 2002 gives the MBESC seven months before the next school year begins to try to simplify the exemption policy. The quality of education issue entails a long-term process, but simplifying this policy is a good place

to start the process. On Rec. 3, it is clear what type of services are available for OVC and what communities particularly need to ensure that those services are provided, but what remains a challenge is linking those communities to the services available. This is an ongoing process which the applicable ministries should monitor and evaluate annually to ensure that the services are trickling down to the children who need them in all regions. We spent a lot of time on Rec. 4. We were going to recommend that insurance companies should be asked to change their policies to ensure that OVC are covered, but in view of what Minister Amathila said about their response to date in this regard, we changed the recommendation in the hope that if private sector companies actively participate, they will understand more about the problems and their magnitude, get to know all the stakeholders better, and then decide to go back to their constitutencies to recommend that policies should be changed accordingly. Parliament is another key stakeholder that should look at how more resources can be made available for OVC. Another issue we discussed – which could be a bit sensitive – is the MWACW's mandate versus the current mandate of the DDSWS. We need to clarify their respective responsibilities for OVC care.

SUMMARY OF GROUP 2 DISCUSSION

EMAILED SUMMARY

Group 2 had about 30 participants representing government, NGOs, churches, educational institutions and international agencies.

The key stakeholders were divided into four groups:

- At the community level: families, churches, CBOs and NGOs should play a primary role in the care and support of OVC.
- The government sector should play a facilitating role in terms of law reform, developing policy guidelines, and policy implementation to ensure OVC access to services and other safety nets.
- Parastatals, private sector, unions and service clubs should provide financial assistance and work in their own agencies to protect staff members who might be infected with or affected by HIV/AIDS, and their dependants. Through service clubs they could also provide funds to the community (as identified at first bullet).
- Development partners and donor agencies should provide technical and financial assistance.

Some critical issues:

- OVC registry: there may be some duplications due to various agencies having their own registries.
- Insurance policies need to be reviewed and changed to ensure the protection of people living with HIV/AIDS and their dependants.
- Law reform: we urgently need to pass the Child Care and Protection Bill, the Children's Status Bill and other bills providing for the protection of OVC.
- Stronger coordination between stakeholders is needed to avoid duplication.
- The involvement of high-level government structures such as the Office of the Prime Minister and Parliament is needed.
- There is a need for stronger community partnerships with government, churches, etc.
- Mandate clarification: we need clarity on the mandate of the MWACW versus that of the MOHSS/DDSWS.

FLIP-CHARTS

Protection and participation rights – gaps:

1. Reports are delayed due to a lack of human rseources.
2. There is a lack of commitment from justice officials in terms of getting involved (particularly in juvenile justice fora).
3. The WCPUs lack human resources from Home Affairs, and they need more social workers.
4. The WCPUs lack transport.
5. The Ministry of Labour does not have the necessary resources or capacity to assist children employed on farms. It is assumed that these children receive food for work, but who protects them if they are exploited, and should they be working in any event?
6. Who protects children used for prostitution and selling drugs?
7. Research carried out by labour inspectors does not reach the relevant aid organisations.
8. The MBESC does not make provision for children aged 10-18 years who cannot be enrolled in either formal or adult education programmes.
9. Bills providing for children's rights have not been passed.
10. Access to information on social welfare grants needs to be improved.
11. The position of traditional healers must be

reviewed so that all parties will accept the role they play in the communities.

Strategies:

1. Traditional leaders and regional councillors to assist with actions at grassroots level.
2. Deputy Prosecutor-Generals to assist at regional level.
3. Train community volunteers to assist with WCPU services and make provision for volunteer incentives. (WCPU partners to budget for volunteer allowances.)
4. Mobilise funds locally and internationally to purchase vehicles for the WCPUs.
5. Take legal action in all cases of economic exploitation of children.
6. Government and donors to make budgetary provisions for OVC programmes.
7. The MBESC to provide literacy classes to enable children aged 10-18 who have never been to school to get an education.
8. Pressurise Parliament to pass the Child Care and Protection Bill, Children's Status Bill, Maintenance Bill, Domestic Violence Bill and any other bill providing for children's rights. (Do this through the relevant ministers and through regional councillors who sit in Parliament.)
9. Regional councillors to advocate for and disseminate information on social safety nets and procedures for accessing them.

PLENARY DISCUSSION ON GROUP 2 REPORT-BACK

Question: On strengthening linkages (Rec. 3), we cannot anticipate that government will ever have enough employees to reach all the communities. Normally this is a job for NGOs, but there is no mention of NGOs linking with the government services for this purpose. Did the group discuss NGO involvement in this area?
Answer: We discussed it extensively. I meant to note it in the report-back. By 'communities' we are including all CBOs and NGOs working at community level. We agree that government will never have enough employees to develop the required linkages, but we think that government extension workers could play a role in facilitating the linking process.

Comment: Churches and religious institutions should be mentioned as a specific role-player in this group's recommendations, since they will be a major and in fact critical role-player in providing holistic care, and they already have the necessary skills and structures in place.
Response: We certainly agree with this. The group identified many stakeholders including the churches. We just didn't specify them all in wording the recommendations, but they will all be noted in the conference report.

Comment: It seems to me that there are no linkages to health and welfare services in some regions. If there are linkages, then they are very weak – maybe due to a lack of capacity. Also, the linkages between the health and welfare services may be very weak or non-existent.
Response: Though they may lack capacity or resources, we definitely do have linkages both to and between the health and social welfare services in every region. The MOHSS has social workers and many health officials working at community level in every region. The MOHSS services are linked to other ministries through the MOHSS regional management teams and district coordinating committees, and these MOHSS structures also work with the regional and constituency development committees. In addition we have various intersectoral fora coordinating social welfare activities, and our health partners are members of these fora. We thus have quite a number of linkages in place, which we just need to strengthen.

Due to space constraints, the last point made in this discussion is recorded in the discussion on Group 4 – see last point p.74.

GROUP SESSION 3

How can we ensure that the rights of OVC are protected?

Rapporteur: Mr Sebastian Timothy,
Director, Destiny Haven

FACILITATORS

Ms Oletu Nakaambo, Development Planner, MWACW
Ms Mariane Shalumbu, Chief Community Liaison Officer for Omusati Region, MWACW
Adv. Michaela Figueira, Coordinator of the AIDS Law Unit of the Legal Assistance Centre

KEY STRATEGY

Develop a National Policy on Orphans and Other Vulnerable Children.

RECOMMENDATIONS

1. Identify key persons for lobbying parliament to pass all outstanding bills, e.g. the Child Care and Protection Bill, the Children's Status Bill, the Education Bill, the Maintenance Bill.
2. Government and donors to make sufficient budgetary provision for programmes serving orphans and other vulnerable children.
3. Legal action should be instituted against those who engage in the economic exploitation of children.
4. Develop and implement mechanisms to facilitate easy access through community structures to services such as education, health, welfare, rights protection and information.

ADDITIONAL NOTEWORTHY POINTS IN THE REPORT-BACK [verbatim reproduction of written report-back notes]

I know we are meant to report back only on our key strategy and recommendations, but because this is so sensitive an issue, I would like to give some background information to contextualise our discussion.

In 1990 Namibia became a signatory to the 1989 UN Convention on the Rights of the Child, which applies to orphans and other children.

In June 1996 parliamentarians gathered to workshop on setting a standard for Namibia's children. Many important issues were discussed and deliberated upon, but what featured prominently was the review process of the outdated Children's Act of 1960 that Namibia inherited from South Africa. In consultation with the various partners and stakeholders, new draft legislation was finalised.

Two acts would replace the Children's Act of 1960: (1) the Child Care and Protection Act, which deals with issues related to child welfare; and (2) the Children's Status Act, which eliminates legal discrimination against children born outside of marriage.

No specific emphasis was placed as a point of discussion during the drafting process on orphans and other vulnerable children, nor was there any mention of HIV/AIDS and its adverse effects on a child, either directly or indirectly.

Today we confer on how we can ensure that the rights of OVC are protected. In doing so, we need to take cognisance especially of the time factor, the used-up resources and the escalating numbers of OVC in Namibia. Over the last two days HIV/AIDS

has been strongly emphasised as a factor contributing to this escalation, but there are several other equally important factors to consider.

For this report-back I have tried to condense about 15 pages of overhead projection sheets to convey what a strategic policy framework should entail, as follows:

- Developing a fair and transparent system for allocating financial and human resources to successfully implement programmes on the care and development of OVC.
- Monitoring and evaluating all systems in place to ensure that OVC are not discriminated against.
- Ascertaining physical facilities to create an environment that is conducive to healthy progress in life.

Further to our four recommendations, we will need to:

- ensure sound organisational commitment, political support and resource availability;
- draw in national leadership to protect not only OVC affected by HIV/AIDS today, but also the future generations of children in general;
- formulate a plan of action to promote and monitor the implementation of the two acts once they have been passed; and
- build capacity to ensure the protection of OVC rights and thus alleviate constraints on future generations of OVC.

The group felt very strongly that legal action must be taken against those who engage in the economic exploitation of children, which is unconstitutional. Two examples of this were given: (1) When labour inspectors confronted a farmer who was using children for monetary gain, they were told that the children receive food in return for their labour, but this is not acceptable in the eyes of the law. (2) A group member who approached some girls working as sex workers was told that they do carry condoms, but they have no food to eat. Many of these young sex workers do not work alone, but rather in groups headed by a businessperson, either male or female, who pays them a salary. They too are breaking the law.

Another group focused on who should take responsibility for various actions in support of OVC. When it comes to protecting children's rights, our group agreed that each and every individual delegate to this conference, and all members of the public as parents, caregivers and concerned citizens, should be collectively responsible. Through all our structures and in all the communities we represent, we have to take joint responsibility for rights education and information dissemination.

SUMMARY OF GROUP DISCUSSION

The discussion was based on the following presentation by Michaela Figueira [using the aforementioned overhead projection sheets as reproduced here]:

THE RIGHTS OF OVC: POLICY AND LEGISLATIVE FRAMEWORK

National response – a human rights-based approach:
As a signatory to the 1989 UN Convention on the Rights of the Child, Namibia has agreed to advance these rights on behalf of children: survival rights; developmental rights; protection rights; participation rights.

Public health and human rights:

- Health and human rights complement and mutually reinforce each other.
- Promotion and protection of human rights are necessary to achieve the public health goals of: reducing vulnerability to HIV and the adverse impacts of HIV; empowering people to respond to HIV/AIDS.
- Shaped by the Constitution: Article 8 on dignity; Article 10 on freedom from discrimination; Article 13 on privacy; Article 15 on children's rights; Article 20 on education; Article 95(j) on health.
- OVC enjoy constitutional protection of their rights to dignity, equality, privacy, education, and freedom from discrimination and economic exploitation.

National Policy on HIV/AIDS (1992):

- Emphasis on need for non-discriminatory environment.
- Information and education for children and youth; HIV/STD education in schools.
- No testing without informed consent and guarantees of confidentiality.
- Determination of HIV status is not a prerequisite for entry to educational or training institutions.

National Strategic Plan (MTP II; 1999-2004):

- To ensure people living with HIV/AIDS are not subjected to discrimination.

- All sectors have the obligation to budget for, initiate and integrate activities to address HIV/AIDS, and to develop prevention and control activities and action plans in line with national policies.

Sectoral obligations:
- Social services: promote and engage communities in caring and support with special emphasis on women and orphans; provide information on benefits.
- Education and culture: integrate HIV/AIDS-related activities and information into all curricula; develop and distribute IEC materials.

HIV/AIDS Charter of Rights (2000):
- Children and adolescents enjoy the same rights as adults with regard to access to information, privacy and confidentiality, respect, informed consent and means of prevention.
- Quality health care, information and education should be available to all children and adolescents, including those living with HIV/AIDS. This should include information on HIV/AIDS and STD prevention and care, inside and outside school, which is tailored appropriately to age level and capacity, and which enables them to deal positively and responsibly with their sexuality and rights.
- Children and adolescents should be ensured adequate access to user-friendly, confidential sexual and reproductive health services. These services should include information on HIV/AIDS and STDs, sexual health advice, counselling, HIV testing and prevention measures, including free access to condoms and social support services. The provision of these services to children and adolescents should reflect the appropriate balance between the right of the child or adolescent to be involved in decision-making according to his/her evolving capabilities and the rights and duties of parents or guardians for the health and well-being of the child.

And the reality:
- Widespread discrimination.
- Lack of access to care and treatment.
- The vicious cycle continues: OVC remain vulnerable to HIV infection and the impact of HIV is exacerbated.

Conclusion:
- Good policy does not automatically translate into good practice.
- Each sector in Namibian society must internalise these policies and ensure their application and enforcement.
- We require a comprehensive approach to rights enforcement.

GROUP BRAINSTORM [from flip-charts]

The rights of OVC:
- Right to protection of all human rights.
- Right to self-determination: requires involving OVC in planning, decision-making and information-gathering opportunities.
- Rights to education, shelter, food, speech. Education must be quality education. Are the MBESC principles being met? There are discrepancies in education standards in urban and rural areas.
- Right to access public health services and proper care and support (i.e. maintenance).
- Inheritance and planning for children after death of parent/s to provide for children's security and ensure material and emotional support.
- Inheritance and guardianship practices differ from culture to culture.
- Children have a right to decide with whom they wish to live after their parents die.
- Extended families have preferences as to which OVC to take in (depending on e.g. what education stage they have reached).
- Educators do not have sole responsibility for educating children; the primary responsibility lies with parents, who must assume this responsibility.
- Query: Do children always know what is right for them? To what extent should they have the right to choose?
- Children should be involved in this planning before their parents die, and parents should bring children into these discussions at an early stage. If this happens, it will be easier for service providers to assess their special needs.
- Right to freedom from economic exploitation (referring especially to farm labour and commercial sex work).
- Courts should utilise the enquiry mechanism in criminal trials involving youth to assess whether a child is in need of care.
- Children must be protected from all forms of abuse.
- There are inadequate facilities for juvenile offenders.

- OVC are most at risk of sliding into criminal behaviour. The answer is not to incarcerate them. We need laws to address this.
- Parents need to be taught about children's rights. There is a discrepancy in awareness of children's rights in urban and rural areas, hence a need to concentrate on improving rural access to information and education on children's rights – educating parents and children.

Who is responsible for implementing and enforcing children's rights?
Answer: The MWACW, MOHSS, MBESC and Ministry of Justice, the regional councillors, organisations working with OVC on the ground, the WCPUs, family members and caregivers, the community.
Problem identified: Implementing agencies do not always report back.

PLENARY DISCUSSION ON GROUP 3 REPORT-BACK

Question: Many children living on farms have no access to education. How are we going to reach them?
Question: Regarding legal action in cases of economic exploitation of children, there are many children under the age of 16 who have no food or clothing and take on work after school hours, e.g. in supermarkets, for a small income that enables them to buy such basic necessities. Did the group deliberate on how this recommendation might affect them? It might deprive them of their only means to acquire these necessities.
Answer to both questions (Mr Timothy and Ms Nakaambo): These questions pertain to education. The participants may or may not be aware that two weeks ago the MBESC released a strategic plan along with a logical framework for implementing it, which clearly states that all children have a right of access to education, and further that all children should be accommodated in the process of learning through primary and secondary education. Exploitation is an effect of vulnerability, which in turn is due to the incapacity of caregivers to care for children. Because farm labourers earn very low wages, and also because of the long distances between farms and schools, the majority of them are unable to cover the costs of sending their children to school. As we heard from the OVC consultant from Zambia, school fees have been abolished in that country, and community schools are increasingly making it possible to provide education for all. When Namibia's two children's acts come into force, all stakeholders in child development will have to help to detect the discrepancies between their provisions and the situation on the ground, and then formulate some kind of policy and guidelines to ensure that the gaps are filled. This will require all the stakeholders to examine the region/s in which they operate to ensure that children on farms and in rural areas generally will be covered by such a policy. The group already identified a gap: children aged 9 or 10 found on the streets who either dropped out of formal schooling at an early age or have never been to school are not accepted back into the formal system nor into literacy programmes precisely because they lack the basic education they need to be able to cope with the programme material or school curriculum at any level. This is a vicious cycle that may necessitate special education programmes for the applicable children. Then, though there are people exploiting children for economic gain, very often you'll find that an older person such as a child's own caregiver is forcing the child to go to work, so it is not only employers who are breaking the law on child labour. We also find cases of money coming into the home through child labour being used to buy alcohol rather than food. This type of child abuse at household level is widespread and must be borne in mind.
Addition from Ms Coetzee-Masabane: These responses make it clear that we have to take a realistic and balanced approach in all our interventions to protect children's rights.

Comment (Ms Mavulu, DDSWS): Rec. 2 is very important because one serious problem is that the

allowances and grants we budget for in a particular financial year get used up before the end of that year. This is because we lack data on OVC, and most specifically on orphans. Linking this recommendation with Rec. 2 of Group 5 and Rec. 1 of Group 4 will enable us to address this problem.

Comment (Ms Shikongo, UNICEF): Regarding child labour, I would like to draw attention to some interesting statistics that the Ministry of Labour has compiled from its recent survey on child labour: 16,3% of all Namibian children are working about 2 hours per week; 80% of those working are still in school and the majority of those not in school are boys; and the number of children working in urban areas is higher than the number working in rural areas. This was a very interesting study and for OVC planning it would be very useful if we all read it.

Response (Ms Coetzee-Masabane): This is good advice. The delegates from the regions should try to obtain a copy of the survey report before leaving Windhoek.

At this point each participant received a handout (the table on the right) denoting the different types of child welfare grants/allowances dispersed by the DDSWS, the beneficiary numbers registered for each type per region, and the present budget allocations for each type. Ms Mavulu of the DDSWS was asked to explain the table.

children who have lost both parents, or who had to be placed in foster care due to abuse or neglect. There is no limit on the number of children per household for whom allowances will be paid, but the norm has been no more than 7. The beneficiary numbers are the numbers registered with the DDSWS, not the total numbers of orphans and children in need of care in reality.

Comment (Ms Katjiuongua , DDSWS): I hear expressions of surprise at the distribution, e.g. only 1 MG1 beneficiary in the Caprivi. I must admit that

Allowance Type		MG1	MG2	MG3	FPA1	FPA2	FPA3	FPA4	FPA5	FPA6	FPA7	Total per Region
Region no	Region Name											
1	Kunene	61	28	28	8	6	3	1	0	0	0	135
2	Omusati	4	2	20	0	1	0	0	0	0	0	27
3	Oshana	15	19	55	7	1	2	1	0	1	0	101
4	Ohangwena	5	4	13	1	2	0	0	0	0	0	25
5	Oshikoto	42	18	14	10	9	2	0	0	0	0	95
6	Kavango	2	5	12	7	2	6	1	0	0	0	35
7	Caprivi	1	0	0	0	0	0	0	0	0	0	1
8	Erongo	136	57	26	37	14	3	1	0	0	0	274
9	Otjozundjupa	150	91	76	26	14	8	3	1	0	0	369
10	Omaheke	159	91	74	12	14	4	2	1	0	1	358
11	Khomas	372	263	200	43	30	5	4	0	2	0	919
12	Hardap	387	277	168	84	34	24	5	2	0	0	981
13	Karas	290	115	107	46	20	7	2	0	0	0	587
	TOTAL	1624	970	793	281	147	64	20	4	3	1	
	Amount	324,800.00	291,000.00	317,200.00	56,200.00	44,100.00	25,600.00	10,000.00	2,400.00	2,100.00	800.00	

Total for all Regions 3907

Amount for all Regions 1,074,200.00

we in the DDSWS have also found it difficult to understand the distribution, which is inequitable, and this is a serious concern for us. For one thing, regions that have benefited more historically are still benefiting more. One would imagine that the Caprivi and Kavango would have higher numbers benefiting in view of AIDS and the recent conflict situation in those areas. People in those regions are not coming forward to make needy children known to us. Many more children in those areas should be benefiting. We wanted to make you aware of the situation, which we have to address. If we do not have enough funds to cover all children who should benefit, then the funds we have should at least be distributed equitably across the country. You should take this information as a messgae from the DDSWS.

Addition from Dr Steinitz, CAA: I appreciate and want to follow up on these comments. I also find this distribution extremely disturbing, as we probably all do. In CAA's experience most of the current need is in the northern regions. I propose that Group 3 should set aside time during the course of the day to talk about this and at least recommend that redressing the concern or the structural factors maintaining the unequal distribution should be addressed as a priority conference recommendation.

Comment (DDSWS social worker, Omaheke): I question these figures since the total number of FPA beneficiaries in the Omaheke is 34, I myself have more than 34 FPA beneficiaries on my books, and there are still two other social workers in the Omaheke office.

Comment (Ms Mabengano, Caprivi social worker): The table is not a true reflection of the Caprivi situation. Last year we paid MGs to 24 people, and 60 people are now waiting for these grants. Fostering is still a foreign concept in Caprivi, but we're doing our best to educate the people and make the assistance available.

Response (Ms Coetzee-Masabane): We must bear in mind that Ms Mabengano has been the only social worker in the Caprivi for many years now, and she is doing an excellent job in keeping the work going there.

Comment: One of the conference objectives is to devise an action plan that will enable us to reach hard-to-reach areas. The inequitable distribution may be due in part to the fact that in regions like the Caprivi and Kavango, many of those affected by AIDS and political conflict live in hard-to-reach areas and simply still don't know that there is help available and/or where to seek it. Returning to Rec. 3 of Group 2 on linkages, special attention should be paid to developing linkages in hard-to-reach areas.

Comment: It must be noted that government found a discrepancy in the distribution of grants due to these having been distributed according to ethnic group before independence. A real distribution grant to suit every situation in the country has yet to be finalised. It should also be noted for the sake of working mothers who want to apply for maternity benefits, these are awarded according to the number of children a woman bears. For one child she will receive 80% of her salary while taking her three-month maternity leave, for two children 60%, for three children 50%, and thereafter nothing. In other words, Namibia also has to consider the social implications of cultural practices like bearing more children to increase household income. In view of the current realities, people will have to plan more constructively for the future.

Final word on distribution of grants and allowances (Ms Coetzee-Masabane): We have reached consensus that the conference should recommend addressing the grant distribution situation as a priority.

Comment: Insurance companies which don't cover people affected by HIV/AIDS must surely realise they they have been benefiting from all premiums, for example by investing clients' monies in building ventures. But the money they use to build their castles is not their own money; it came from the hard sweat of others. Perhaps we need to look at legislation to ensure the participation of insurance companies in multi-sectoral activities to assist needy people, many of whom are still their clients. Likewise private companies generally. Their involvement in any activity is guided by marketing strategy, so we need to find out to what extent they will get involved in an OVC programme.

GROUP SESSION 4

How can we use current prevention and care activities to support and promote OVC?

Rapporteur: Ms Eveline Nuujoma-Kalomo,
Women and Child Protection Unit (Windhoek)

FACILITATORS

Ms Sarah Bowsky, OVC Specialist, Family Health International
Mr Abner Xoagub, Manager of the National AIDS Coordination Programme, MOHSS
Mr Shamani-Jeffrey Shikwambi, Coordinator of the National ECD NGO Association

KEY STRATEGY

Strengthen existing prevention and care activities through a multi-sectoral and coordinated process whereby they become community owned and of direct benefit to orphans and other vulnerable children.

RECOMMENDATIONS

1. Develop an inventory or database of existing services, partners and resources involved in HIV/AIDS prevention and care, and care and support for orphans and other vulnerable children (including medical, social welfare, psychosocial, and human and legal rights), and an implementation plan for this inventory or database.

2. Build and utilise the capacity of:
   - services providers, who should be better able to address the needs of orphans and other vulnerable children in respect of HIV/AIDS prevention and care; and
   - communities, which should identify problems, orphans and other vulnerable children, coping mechanisms, internal and external resources, and which should have the capacity to design and implement their activities and solutions.

3. Increase awareness of and access to services relating to and organisations working with HIV/AIDS and orphans and other vulnerable children, including medical, social welfare, psychosocial, and human and legal rights services and organisations.

4. Develop standardised monitoring and evaluation mechanisms at national and community levels to ensure that orphans and other vulnerable children are benefiting from services and activities.

ADDITIONAL NOTEWORTHY POINTS IN THE REPORT-BACK

We based our deliberations on the following quote:

"Involve children and the youth as part of the solution, not as part of the problem: Children are not simply a passive, powerless target group to be aided, but rather they are capable actors and important resources to engage in the community response to AIDS."

SUMMARY OF GROUP DISCUSSION (reproduction of email)

Most of the current HIV/AIDS prevention and care activities in Namibia can be used either directly or indirectly to promote and support orphans and other vulnerable children (0-18 years of age). This includes peer education, voluntary counselling and testing, home- based care initiatives, and legal and human rights initiatives. Following are examples of how some of the elements of current prevention and care activities in Namibia can be strengthened to promote and support the well-being of OVC.

Some of the current specific prevention efforts in Namibia, including "Worth Waiting For", "My Future My Choice", and Early Childhood Development", can be used to directly support and promote the well-being of OVC by way of expanding the age groups they are working with and incorporating training on issues relating to OVC to increase awareness and understanding of the issues. Any STD control programmes can intensify efforts to increase health-seeking behavior of youth and OVC. Targeted STD interventions for OVC at risk (e.g. street children, abused children and juvenile offenders) will also support OVC. Additional means of supporting OVC within HIV prevention are child-to-child and youth-child interventions, which have not yet been fully utilised in Namibia.

The constraint of using voluntary counselling and testing activities to promote and support OVC is the current lack of quality, consistency and standards. Efforts to address these challenges could include a pre-test counselling component related to the benefits of having an HIV test so that individuals are better able to plan for the future of their children. Post-test counselling can also address children's issues and VCT could be used as an entry point for activities around OVC such as support groups for those who test positive including general VCT sites and those at antenatal clinics.

Current psychosocial activities related to HIV prevention and care are fragmented and have not yet been fully assessed or given the attention needed. Activities in this area need to be expanded, and adequate human capacity, resources and referral systems put in place, especially in rural areas. Various psychosocial activities are already taking place, including individual counselling, bereavement counselling, and spiritual and supportive counselling. These are excellent avenues both for providing counselling for children and for addressing issues related to children together with adults. Teachers, church members and other key community members can play an active role in identifying children who are experiencing psychosocial difficulties, but they will need skills to identify them, to emotionally support them and also to refer these children to other support mechanisms. There is a critical need to increase dialogue and create strategies to promote and maintain rituals and traditions that help to strengthen children emotionally and to strengthen their sense of social identity. These rituals and traditions are related to grief processes, cultural activities and lineage.

Various organisations have become involved in home-based care, primarily CAA and the MOHSS, but they have not been able to meet the demand of households in need and the quality of care still needs to be strengthened, as do linkages with the formal health-care institutions. Home-based care promotes and supports OVC since it also entails counselling parents apropos preparations for their children's care upon their death, and because the volunteers build relationships with their clients. There is also a need to ensure that children are spoken with and listened to during volunteer visits to the home, so the volunteer can assess the well-being of the child and make referrals as needed. This will also allow for discussions that can promote preventative behavior among children, as they are witnesses to the physical and emotional effects of AIDS on the client in the household. After the death of a parent or guardian, volunteers should be encouraged to continue visiting the children to follow-up on their status and needs. More efforts must also be made to provide home-based care to youth and children living with HIV.

Access to legal services to protect human rights is very important for promoting and supporting OVC. Inheritance laws and legal services should be more inclusive in terms of protections for children's rights and future well-being. Will-writing assistance given to parents needs to be expanded, and we need to put mechanisms in place to ensure that wills are abided by. Laws and policies should include mechanisms to decrease stigma and discrimination of OVC, and these will require proper implementation strategies which also ensure widespread awareness and application.

Social mobilisation is taking place at all levels in Namibia, both formally and informally. But the

momentum has not been fully captured, the intensity of mobilisation efforts differs from organisation to organisation, and thus there is a need to create a standard definition of social mobilisation, as well as to increase collaboration among the partners and close the gap between community-level and programme-level mobilisation. Social mobilisation can be used to better understand and rally people in support of OVC, improve access to activities and services, build the capacity of communities to address OVC needs through identification of their problems and solutions to them, and to advocate on behalf of OVC at community and national level.

Although post-exposure prophylaxis (PEP) has not been fully implemented in Namibia as yet, implementation should include PEP for abused children.

PLENARY DISCUSSION ON GROUP 4 REPORT-BACK

Question: What does "Build and utilise the capacity ..." mean in practice at community level?
Answer: We discussed capacity-building at length and the details will be recorded in the conference report. One major aspect of this is to build on and utilise the knowledge and skills that communities already have for identifying OVC. The group also talked about producing a training manual that sets out the options and procedures for assisting OVC.

Comment: Rec. No. 4 is an extremely valuable and important one. It's easy to sit in Windhoek and plan projects and then report to the MOHSS that we're doing this and that, but without an evaluation and monitoring tool we can never say that we really are achieving what we claim to be achieving.

Question: Your introductory quote rightly states that children should be regarded as part of the solution rather than as part of the problem, but your recommendations don't seem to reflect that statement.
Answer: Rec. 2 does reflect this. We had a very long discussion about how we can empower families and communities to bring them on board, and we include children in speaking of families and communities. There are many ways to involve children in seeking solutions.

Question: Education doesn't feature in these recommendations. Did you discuss education?
Answer (Ms Coetzee-Masabane: We will hear about education from two other groups which dealt with this issue.

Comment (Ms Kruger, Lifeline/Childline): I want to note our experience that the more the NGOs work together, the more trust there is among communities to contribute to the NGOs. Over the last seven months we've had quite a few offers of items like food and clothing, the distribution of which is not one of our own objectives, but because of our close links with NGOs that do need such items to meet their objectives, we could pass them on to the right people. Just last night we had an offer from a school group that wants to start collecting clothes and blankets for distributing to needy children all over the country. One of the group members knows me and had the courage to phone for assistance to get to the right people. We think that the 'how?' is very big, but in fact it is very simple: we must just take hands.
Response (Ms Coetzee-Masabane): Indeed a very important aspect of our work is the need to network, coordinate efforts, and support and complement each other's services.

GROUP SESSION 5

How can we ensure long-term and effective safety nets for our OVC?

Rapporteur: Ms Bernadette Harases,
Control Social Worker, North West Region, DDSWS, MOHSS

FACILITATORS

MOHSS Directorate of Developmental Social Welfare Services:
Ms Laura Cronje, Chief Social Worker for Erongo Region
Ms Loide Nekundi, Chief Social Worker for Ohangwena Region
Ms Bernadette Harases, Control Social Worker, North West Health Directorate

RESOURCE PERSON

Ms N Mavulu, Control Officer for Social Assistance

KEY STRATEGY

Develop and strengthen existing networking forums for OVC at all levels including constituency and regional.

RECOMMENDATIONS

1. Legislation, policies and guidelines pertaining to OVC should be put in place and existing policies should be implemented (e.g. exemption from school funds and access to health care).
2. Information materials pertaining to OVC, such as Resources for Vulnerable Children (one of the conference handouts) should be updated, translated and disseminated for use at grassroots level.
3. Develop and implement an equitable, long-term and sustainable social assistance plan, including a simplified grant system for OVC and their families. (The present grant system is complicated and entails a lot of work for social workers.)
4. Develop a networking system for OVC service providers at all levels.

ADDITIONAL NOTEWORTHY POINTS IN THE REPORT-BACK

The group had many more recommendations [see summary of group discussion]. On Rec. 2, some mistakes and outdated information had been found in the resource manual, and the group would communicate these to the DDSWS.

SUMMARY OF GROUP DISCUSSION
(transcription of flip-charts and notes)

The group came up with the following working definition of 'safety nets': "The provision or availability of protective and nurturing measures in order to ensure the well-being of OVC and to enhance their psychosocial development to attain balanced adulthood."

Safety nets identified:
1. Social welfare assistance.
2. Institutions: children's homes; places of safety;

WCPUs; pre-schools, primary schools, high schools, industrial schools.
3. Extended families; families; communities (community resource persons, foster care, adoptive parents, etc.); churches.
4. Legislation: international intruments
5. Financial provisions: insurance; GIPF; Master of the High Court (estate allowances); Social Security Commission; health care; counselling; clubs; after-school activities; exemptions from school funds, hostel fees and uniforms; international concern/interest (funding for projects); community initiatives and mobilisation; juvenile justice system.

Problems in accessing safety nets:
- Lack of information
- Delays in payment of grants and allowances
- No policy guidelines and manuals regarding OVC
- Inaccessibility to social services
- Lack of infrastructures
- Long-term (un)sustainability of grants and allowances
- Outdated legislation
- Lack of support for caregivers
- Lack of human resources and vastness of areas to be covered
- Lack of supervision and/or monitoring in handling of grants, pensions and estate allowances due to lack of (professional) human resources
- Difficulties in accommodating OVC in schools
- Juveniles incarcerated with hardcore/adult criminals
- Essential services not customer-friendly

Gaps in the safety nets:
- Lack of facilities willing to take in children with HIV/AIDS and disabilities
- Age restrictions in institutions
- Lack of training to provide user-friendly services
- Services are centralised in larger centres
- Lack of information within communities to address the needs of OVC
- Lack of transport to provide services to communities
- Lack of national orphan register
- Lack of services for children with behavioural problems
- Lack of services for children with learning problems (e.g. vocational training in lower grades for children who started school late)
- Volunteers have work permit problems
- Lack of support for extended families caring for OVC
- Lack of coordination for funding services

Social assistance considerations:
- Disability grants for children under 16 years should be looked at.
- Number of children on maintenance grants
- Time taken for a foster parent grant to go through
- Need to simplify grants for OVC (e.g. maintenance grant for family members who foster – not the foster-care process)
- Need for projection and planning to ensure long-term availability of funds
- Financial support for HIV-positive children (baby formula, etc.) to meet immediate needs, or national policy on services for HIV-infected mothers
- How to make social assistance sustainable
- Social assistance application documents
- Need for revising the subsidy system for institutions caring for OVC

Inheritance considerations:
- Need to inform communities about wills
- Insurance payouts to cover the care of the children; companies should not pay out claims to families/children in a lump sum
- Need to address discrimination against HIV-positive persons in relation to insurance
- Estate allowance procedures should be simplified
- Need to implement a policy for dealing with children unable to pay for medical services

Education considerations:
- Children unable to pay are not admitted
- Communities need information on how to obtain school, hostel and examination fee exemptions (i.e. Learner, Parent, Caregiver Charter)
- Need for special programmes for dropouts and older children not in school
- Need for school feeding schemes
- Need for assisting OVC with homework

Other recommendations (in addition to the first four):
5. National policy on OVC should address the nutritional needs of OVC, e.g. baby formula and school feeding schemes.

6. Revise the subsidy system for institutions caring for OVC.
7. Raise community awareness regarding wills.
8. Simplify the procedures regarding estate allowances.
9. Address the issue of insurance companies discriminating against HIV-positive people.
10. The MBESC must disseminate the Learner, Parent, Caregiver Charter to communities.
11. Special programmes should be put in place for children not in school and children with behavioural and learning problems.
12. Compile national and regional registers on orphans.
13. The MOHSS should streamline the issuance of national documents such as IDs.
14. The National Steering Committee on OVC should look at strategies for addressing the psychosocial needs of OVC.

PLENARY DISCUSSION ON GROUP 5 REPORT-BACK

Question: Rec. 2 is very valid. Information dissemination is one of the key issues we have to address. How do the ministries presently inform the public of social services available and rights like school fee exemption? Is there a centre where people can go to find materials like pamphlets? This conference has noted that people don't know their rights, so the MOHSS is strongly urged to look at the issue of information dissemination as a high priority.

Answer (Ms Mavulu, DDSWS): The DDSWS has a social work office in each of Namibia's 13 regions. Through these we have distributed pamphlets describing the DDSWS's aims and objectives. We have also broadcast radio talk shows to inform people about the grants and allowances available. We are now going to update the service resource manual and distribute the updated version to every region. We have good communication with the regional governors and councillors, and we think they will assist with information dissemination.

Question: Please elaborate on Rec. 4: what kind of network is this? Is it just a list of names?

Answer (Ms Harases, DDSWS): We want to avoid putting up new networking structures. We have the Regional AIDS Coordinating Committee (RACOC) structure, but we feel this is not the appropriate structure for dealing with OVC. Rather, all OVC service providers should form a forum that meets at least once a month to discuss issues, budget, plan and report back, so we always have a comprehensive support plan for OVC in all regions.

Addition from Ms Coetzee-Masabane: A principle decision that this conference should take is whether we should: (a) work through the existing RACOC structure; (b) have a sub-committee of RACOC that deals specifically with OVC; or (c) establish an independent or separate OVC networking, coordinating and monitoring committee.

Comments on link to RACOC:

1. A sub-committee on OVC within RACOC would be best as there are RACOC structures (and various other regional bodies) already dealing with OVC issues, and a new structure would effectively duplicate and complicate the activities of the existing ones.
2. We should stop setting up new structures and committees all the time in Namibia. We already have too many doing the same work. We should rather empower RACOC to deal with OVC issues.
3. Many individuals serve on more than one structure, e.g. the regional WCPU committee and juvenile justice forum, and besides the fact that they are always caught up in meetings – so they tend to be absent from many meetings – much of the time they are dealing with the same issues in different forums and this causes problems. It would be best to bring all these people into an OVC umbrella structure so they can address all OVC issues in one forum.
4. Speaking only for the Khomas Region, in our monthly RACOC meetings we go round in circles to the extent that many representatives of the organisations involved don't even attend anymore. Also, meetings don't start on time and people don't have time to hang around waiting. We want to move forward. If the OVC agenda comes under the jurisdiction of RACOC in the Khomas Region, I for one will not participate!
5. Some RACOC structures don't work well, others work very well. There may be benefits to having a structure under RACOC. We must avoid creating a situation whereby RACOC and another structure will have to compete for resources like funds for AIDS orphans.
6. RACOC is mandated to coordinate activities around HIV/AIDS, and this poses problems: (a) it

is not an implementing body; (b) we are not dealing only with OVC affected by HIV/AIDS; and (c) all OVC could end up being labelled or stigmatised as AIDS sufferers.
Proposal (Ms Coetzee-Masabane): I propose that we adopt the group's recommendation that a separate OVC umbrella structure be set up, under which all other structures dealing with OVC issues will be brought together, i.e. the WCPUs, the juvenile justice fora, the street children's forum, the disabilities forum, etc. The conference supported this proposal.
Suggestion (Dr Anttila, HSSSP2): If there is any doubt as to whether this independent OVC umbrella structure will work – and I imagine it will be more an information-sharing and coordinating structure than an implementing one because each party to be involved has its own mandate and statutory role – why not test it in different regions for, say, one year? In a region with a well-functioning RACOC it could be tested as a RACOC sub-committee, and in another region it could be tested as a separate umbrella entity. Still another possibility – in view of the fact that the regional councils are now building their own structures and capacities to improve service provision in various sectors – is that OVC issues could eventually be taken up by the regional councils. Different scenarios like these could be tested and the experiences could be brought to the next conference on OVC.
Final word on OVC structure (Ms Coetzee-Masabane): This is a valuable suggestion, but let us leave questions of piloting and all other technical details on the structure to the National Steering Committee to be formed now. Next year we will hold another conference on OVC to update all stakeholders on piloting results and other matters pertaining to the structure.

Proposal (Dr Steinitz): Rec. 3 of Group 5 will redress the historical inequalities that we have lived with for so long. I propose that it should be addressed with the utmost urgency.
Response (Ms Coetzee-Masabane): In further prioritising the recommendations, the National Steering Committee will be asked to ensure that this one enjoys the utmost priority.

Continuation from p.65 – last points made in the discussion on the Group 1 recommendations:

Comment: In considering OVC identification we must also consider community input into ensuring that the assistance is really reaching the children. In most cases, in fact, it doesn't reach them. We need to look at this problem very seriously because we might produce more OVC out of the system.

Suggestion: Since we lack human resources in both governmental and non-governmental sectors, and since we are looking at basing an OVC programme on community voluntarism, we could perhaps tap into our National Youth Service. For example, through the Ministry of Higher Education, Training and Employment Creation as another stakeholder, we could look at possibilities for utilising unemployed youth in the OVC programme. Though the National Youth Service is currently experiencing some problems, these will certainly be ironed out in time. This structure could play a major role in a programme serving OVC.
Response (Ms Coetzee-Masabane): This is a good proposal. In fact yesterday I facilitated a National Youth Conference session focusing mainly on orphans, and since the youth want to do something to assist orphans and other vulnerable children, I invited them – on behalf of this forum – to elect a representative to our National Steering Committee on OVC. I hope I was not stepping out of bounds in doing so, but I felt that they should join our programme rather than develop their own separate OVC programme.

FINAL SESSION: Adoption of recommendations and Formation of National Steering Committee on OVC

Session chairperson: Ms Petronella Coetzee-Masabane,
Deputy Director of Developmental Social Welfare Services, MOHSS

The participants were asked if they felt that consensus had been reached on the group proposals so that these could be formally adopted as the conference recommendations. The response was unanimously in the affirmative.

The participants were then asked to decide on the time frame for implementing the programme as a whole. Ms Coetzee-Masabane noted that the recommendations would still be broken down into action plans, with clear time frames and actors specified for each one. She reminded the participants that they had already agreed to have an annual programme review, thus they would be brought together again next year to evaluate their progress and determine whether or not they were still on track in the light of any changes or new priorities arising in the interim. A 3-year and a 5-year time frame were proposed. A 5-year time frame was considered to be more realistic, though some participants felt this to be too long. A decision had to be taken quickly since time was running out, and a 5-year time frame was adopted without further discussion.

The next step was to form the National Steering Committee on OVC. Each group was asked to name their two nominees – one of whom should be based in Windhoek and one in another region [see instructions to the groups, p.60]. The nominees were as follows:

Group 1: Selma Shejavali (Windhoek); Cecil John Clark (based in Erongo Region)
Group 2: Amanda Kruger (Windhoek); Jason Haihambo (based in Oshana Region)
Group 3: Sebastian Timothy (Windhoek); Marianne Shalumbu (based in Omusati Region)
Group 4: Eveline Nuujoma-Kalomo (Windhoek); Erika van Rooi (based in Hardap Region)
Group 5: Betsy Basson (Windhoek); Salina Engelbrecht (based in Omaheke Region)

[See table on p.91 for details of the post, organisation and contact address of each committee member.]

All the nominees accepted their appointment. Ms Coetzee-Masabane welcomed the committee and wished the members every success in implementing the programme, adding that "We are all behind you!" In response to a comment on the committee's performance, Ms Coetzee-Masabane noted that members who do not perform to expectations could be voted out and replaced at the annual programme reviews. She then asked how the participants felt the chairing of this initiative should be dealt with, and what entity or organisation (governmental or non-governmental) should act as the secretariat, since there was no budget in place for the programme as yet and the availability of telecommunications and other office equipment would have to be ensured. The participants were asked to put forward proposals on the chairing and secretariat.

Proposal (Lavinia Shikongo, UNICEF): The DDSWS has very successfully coordinated the whole conference process, and we must not lose momentum. I therefore propose that if it is possible, the DDSWS should continue in this capacity by coordinating the committee – at least in the interim. This will greatly help to ensure that we have a clear and time-bound plan and smart objectives, with clear actors to maintain the momentum of this conference. If this is possible, then all of us must do all we can to raise funds to assist the DDSWS in this task. We must ensure that we do not come out with nothing but another conference report. One year from now we should be able to see real achievements. This is not an issue we can afford to put off any longer. In fact, it is hoped that our collective priorities will be reflected in our individuals work plans. With all this in mind, I recommend that the DDSWS leads the committee at least for the time being.

Response from Ms Coetzee-Masabane: I Thank you on behalf of the DDSWS for the trust that you are placing in us. We promise not to disappoint you!

This proposal was met with loud applause. Ms Coetzee-Masabane asked if there were any counter-proposals. There were none.

Comment: I think it is necessary to have an actual chairperson, because we need to know who exactly is responsible.

Proposal (Dr Steinitz, CAA): I propose that Petronella Coetzee-Masabane should be the chairperson, and that she should have the right to add people to the committee as she feels appropriate to carry the work forward.

This proposal was likewise met with loud applause. Ms Coetzee-Masabane asked if anyone objected. There were no objections.

Response from Ms Coetzee-Masabane: Thank you very much. I accept in all humility. I will now read out the terms of reference for the committee – copies of which were given to the working groups – which the conference still has to adopt.

Terms of Reference of the National Steering Committee on OVC

The draft terms of reference were read out twice. They are not recorded here; instead, the final terms are recorded on the next page. One clause was amended and one clause was added:

- The "three-year plan of action" was changed to a "five-year plan of action" as agreed at the start of the session.
- A clause on who the committee should report to was added after the following comments and responses.

Comment: I think it is necessary to add a point specifying who the committee reports to, and also noting the decision just taken that the DDSWS has been given interim responsibility for acting as the secretariat.

In response to this comment Ms Coetzee-Masabane called for proposals on who the committee should report to. There were two proposals:

- It should report directly to the Minister of Health and Social Services.
- It should report to the conference.

Suggestion: One of our problems in Namibia is that the stakeholders in fora like this are so widely dispersed – both geographically and between sectors, since we are government bodies, NGOs, etc. Might it be viable that we as the stakeholders in the OVC programme act as members of an 'organisation' or a 'society' that holds an AGM, and that this conference is deemed to be the AGM, and that at this AGM the National Steering Committee is required to report back to the members. This may not be realistic, but perhaps there is a need for such an arrangement because it would give everyone voting power.

Comment: The committee should report to all the stakeholders rather than to the MOHSS alone, because it is not the sole responsibility of the MOHSS to ensure that what we have decided here is implemented.

Comment: We are dealing with different levels and different reporting relationships at each level. We

have agreed to meet annually, so it is obvious that the committee will be reporting to this conference. But the committee chairperson works under a Minister, and must thus report to that Minister – who in effect heads the whole effort. The Minister in turn will have to brief and coordinate with her colleagues at her level so that something can happen while we, the stakeholders, wait for the committee to report back to us on an annual basis.

Response (Ms Coetzee-Masabane): I agree that this makes sense: we have to report to our Minister in any case, but ultimately the committee must report to the conference. Can we adopt this as a further term of reference?

The plenary agreed to do this.

Final Terms of Reference of the National Steering Committee on OVC

- Prioritise conference recommendations and strategies.
- Develop a five-year plan of action with an annual review.
- Draft a national OVC policy and guidelines for implementation.
- Ensure effective transfer of information and communication to and between all stakeholders.
- Devise an effective monitoring and evaluation tool to ensure collaboration and coordination of programme implementation.
- Report to the Minister of Health and Social Services between conferences, and to the annual conference of stakeholders on OVC.

Closing votes of thanks

Petronella Coetzee-Masabane, Deputy Director of Developmental Social Welfare Services and Chairperson of the National Steering Committee on OVC

Dear colleagues –

I would like to thank you very much for your very very good cooperation over the last three days. I think this has been an excellent conference. You have shown strong commitment; I haven't seen any empty chairs or participants disappearing! Please remember that you are all now part of this general assembly on OVC, and as such you will be called back next year so that your executive can report back to you. Let us give ourselves a round of applause for our dedication.

I believe that the organising committee has done an absolutely outstanding job, and I thank its members very much.

Our sponsors have been very flexible and accommodating. I hope that all our sponsors will stay with us – like our shadows! – for the next five years. I have mentioned them before in the proceedings, but I think they deserve to be mentioned again:

- Family Health International, thank you for the major role you have played in organising and supporting this conference.
- Likewise our long-time and trusted friend UNICEF.
- The Government of Finland's Health and Social Sector Support Programme (Phase 2), has done a tremendous job in building the capacity of the DDSWS and supporting us for the past five years. HSSSP2 has in fact enabled the DDSWS to move from being very much an 'orphan' within the MOHSS to being its rightful and equal 'partner'.
- USAID is an organisation that has not been prominent in this field, but which from the start – when the idea for this conference was just a seed – has been pledging to us its full support with resources, technical expertise and whatever we needed, with absolutely no expectation of acknowledgement or publicity of any kind. We are very grateful, and I ask that this be conveyed to the management/directors in Namibia.
- I also want to acknowledge the assistance and willingness of UNAIDS to support us.
- We invited only two international experts, namely Mulenga Kapwepwe from Zambia and Sara Bowsky from the US, and I thank them very much for sharing their expertise with us, which I hope we can draw on in the future for

the challenging task ahead.

- Lastly, thank you Prime Time Media for your invaluable assistance in organising the conference. Lavinia Shikongo would like to express our special thanks to Esmé Kheibes of Prime Time Media [now FHI].

Lavinia Shikongo, UNICEF

In organising an event there are always people in front and people at the back. Esmé is really the person who made this event happen! She was there at night, she stood in for her boss if he was unable to attend a meeting ... she did all this extra work with so much humility ... always friendly and smiling ... . We have very much appreciated her involvement!

Lavinia Shikongo presenting a special token of appreciation to Esmé Kheibes of Prime Time Media for her work in organising the conference.

Ms Coetzee-Masabane then selected four participants at random to say something to officially close the conference.

Monica Garoes, After School Centre, Windhoek

I have been caught off guard! I will just say that I congratulate the organisers and all participants. I believe we can say with one voice that we have benefited greatly from this venture. We have learnt a lot, but we must not stop here; I hope all of us will go out and share what we have learnt, and really make our learning worthwhile. Thank you for all the contributions. They have helped a lot to empower us and build our capacity.

Cecil John Clarke, CAA Erongo and National Steering Committee on OVC

I feel a strong sense of gratitude and joy to have been a part of this gathering. As a layperson from the grassroots, it has been very heartening to witness the commitment of the line ministries to caring for our needy people, and to drawing the grassroots firmly into this effort. I think the organisers and all participants deserve a very loud hand of applause! Thank you.

Ms Agnes Tom, Bernhard Nordkamp Centre, Katutura (Windhoek)

It has been a great pleasure to see so many people gathered to talk about OVC. At last something is being done! I hope we are all now aware that the issue at hand is pressing and there is no way we can postpone action any longer. I hope the committee will really stick to the time frame, and I hope that HIV-positive children especially are helped because they are very much in need. Thanks very much for this conference!

Ms Elsie Beukes, Master of the High Court

I want to thank everyone for really caring about these children. I hope that when we return next year we will find that we no longer have so many problems. I wish you the best of luck. We at the High Court will support you as far as we can, so if you need us, please call on us! Thank you.

The conference ended with the singing of the national anthem. The participants were invited to attend a brief reception at the venue later in the afternoon.

CONFERENCE EVALUATION

The participants were asked to complete an evaluation form at the end of the conference. Following is a summary of the 98 forms handed in. There were 7 questions posed.

What did you like about the conference?
The conference was well organised, structured, and it ran smoothly. Participants particularly liked the presentations on the first day, and especially that of the OVC consultant from Zambia. There was commitment from all those who attended.

What did you dislike about the conference?
Very few dislikes were expressed. These were the only ones:

- More high-level policy makers should have attended.
- Some speeches were too long.
- The faulty microphone system.
- Some breakout sessions were too long.
- Trying to find the cameraman so as to be interviewed for the conference video.
- Cellphones disrupted the proceedings.
- There should have been orphans present.

Do you feel that we provided you with enough information regarding OVC?
The answer to this question was a resounding YES. One or two participants felt that the focus on orphans was too heavy and that we should have provided more information about other vulnerable children.

What breakout session did you attend?
Sessions 1 and 2 were the best attended, with the remaining three attended by equal numbers of participants.

Do you feel that the breakout session met its objective?
The answer to this question was again a resounding YES. Some people felt that certain sessions were dominated by certain agencies.

How will you now support OVC?
From the answers to this question it is clear that the participants are going to become very active or at least increase their activity around OVC. They intend doing the following:

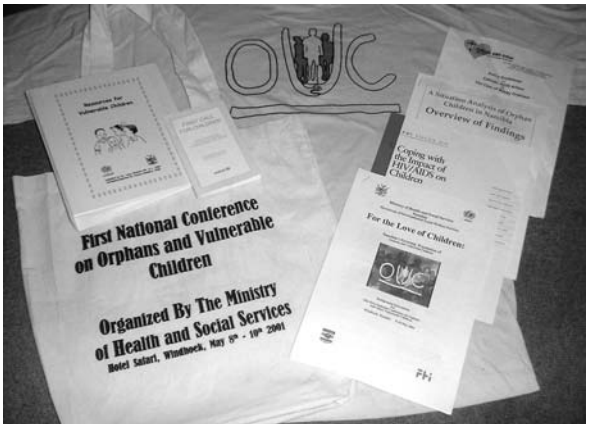
- Provide information and education.
- Provide food.
- Contribute to the MBESC debate around free education for OVC.
- Provide financial resources.
- Take the message back to the regions, set up regional networks and coordinate with the National Steering Committee.
- Focus more on HBC and health outreach.
- Use existing structures to better serve OVC.
- Ensure good planning and coordination of activities around OVC.
- Intensify own outreach efforts through the Regional AIDS Committees.
- Ensure that the national policy on OVC is implemented.
- Ensure implementation of the conference recommendations.
- Ensure that the private sector is involved.
- Do everything possible – with God's help.
- Contribute to this cause with all I have.

Any other comments?

- Good luck to the steering committee. I hope it will work hard!
- Time to stand up and put words into action!
- We should have orphans and caregivers at our future conferences so they can decide what they need and not have their needs decided for them.
- I hope all of the conference outcomes are implemented.
- I leave here with a better understanding and a deeper sense of responsibility.
- Everyone should take responsibility.
- I will eagerly await the feedback at our next meeting.
- People should stop criticising the churches and start recognising their contributions.
- The private sector must be given a seat on the steering committee.
- Conduct a survey of people living far from clinics and social workers to gauge the effects of this distance on OVC.
- Review the information on social welfare organisations and emphasise networking and

coordination.
- Arrange stakeholder study tours to countries with success stories they can learn from.
- Encourage community self-help groups so that OVC are not reliant on donors.
- Presentations from more organisations doing OVC work would have been useful.
- The DDSWS must sensitise organisations on OVC.
- I would like to see OVC themselves speaking in the conference video.
- The MOHSS must ensure the commitment of all the stakeholders in the planning and coordination of activities around OVC.
- Workshops on OVC should be organised in the regions.

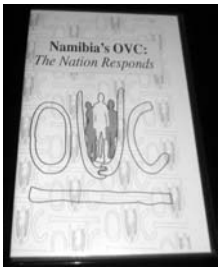
CONFERENCE HANDOUTS AND VIDEO



Each participant received a 'hold-all' bag with the conference title printed on one side and the conference logo on the other, containing the following resource materials:

- Resources for Vulnerable Children, a manual compiled in 1999 by Dr Lucy Steinitz of CAA, and reviewed and updated in 2000 by Vezera Kandetu.
- First Call for Children: World Declaration and Plan of Action from the World Summit for Children, a booklet published by UNICEF. (The Convention on the Rights of the Child is included.)
- "For the Love of Children: Namibia's Growing Population of Orphans and Vulnerable Children – Background Information for the First National Conference on OVC in Namibia", prepared by the DDSWS.
- "Policy Guidelines for Catholic AIDS Action on the Care of Needy Orphans", adopted in 1999.
- "A Situation Analysis of Orphan Children in Namibia: Overview of Findings", prepared by SIAPAC for the conference.
- "Coping with the Impact of HIV/AIDS on Children", an information pamphlet on the approach of FHI.

Each participant also received a bright yellow T-shirt with the conference title printed on the front and the conference logo on the back.



NAMIBIA'S OVC: The Nation Responds

This 36-minute video starts with a brief account of the OVC situation in Namibia to make the viewer aware of why a national response is essential. It goes on to sum up the conference proceedings. The blurb on the video cover states: "... It turned out to be one of the most successful conferences ever held in Namibia. [It] was attended by approximately 200 delegates from all over Namibia and abroad. The content of this TV programme is mainly dedicated to the deliberations and recommendations of the First National Conference on Orphans and Other Vulnerable Children." It presents key snippets of the opening speeches, the expert presentations and the panel discussion; a comprehensive account of the questions posed to the working groups and their recommendations as adopted by the plenary; an interview with the Chairperson of the National Steering Committee on OVC; and interviews with several participants. The video was produced by Jackson Swartz and cameraman Vernon Rassweiler of Prime Time Media. The Government of Finland covered the production costs, and USAID and FHI sponsored the copies. The video is obtainable from the DDSWS head office in Windhoek.

LIST OF PARTICIPANTS

ORGANISATION; REPRESENTATIVE'S NAME AND POST	POSTAL ADDRESS	TELEPHONE	FAX
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Mr Peter Enjambi, Regional Councillor, Omusati	P/Bag 523 Ombalantu	065-251019	251078
Mr Alberth Tjiuma, Chief Clerk, Kunene Regional Council	502 Opuwo	065-273007	273077
Mr WT Biyasi, Coordinator, Council of Traditional Leaders	PO Box 120 Windhoek	061-271046/ 081-124 9808	271046
Mr T Ilenga, Government Institutions Pension Fund	PO Box 23500 Windhoek	061-2051111	2051209

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Ms T Stibbard, Khomas Region	PO Box 21083 Windhoek	061-234221	218665
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Ms Anna McNab, Hardap Region	PO Box 52 Mariental	063-242129	242396
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Mr Gerrit Nantes, Karas Region	PO Box 56 Keetmanshoop	063-226061	226061
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Sister Gertrud Akundungila, Ohangwena Region	c/o PO Box 7 Oshakati	065-254539	254539
Mr Efraim Iipinge, Oshana Region	PO Box 2 Oshakati	065-222851	222851
Ms Ria Kakelo, Oshana Region	PO Box 2 Oshakati	065-222851	222851
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Ms Mary Simbuwa, Caprivi Region	P/Bag 1019 Katima Mulilo	066-254272	254272
Sister Margaret Shintango, Kavango Region	P/Bag 2075 Rundu	066-255829	255184

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Ms Estelle Labuschagne, CBB	PO Box 3307 Windhoek	061-237296	227287
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Rev. Dr Henry Platt, United Reformed Church	PO Box 331 Windhoek	061-213311	213311
Mr L Runyon, Youth for Christ	PO Box 20814 Windhoek	061-234889	234891

OTHER LOCAL NON-GOVERNMENTAL AND COMMUNITY-BASED ORGANISATIONS (NGOS AND CBOS) AND EDUCATIONAL INSTITUTIONS			
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Ms Verina Abrahams, Women's Action for Development (WAD), Khomas Region	PO Box 370 Windhoek	061-227630	236372
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Ms Julianne Breitenfeld, AIDS Care Trust	PO Box 8179 Bachbrecht (Whk)	061-259590	218673
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Mr Frans Gaoseb, Namibian Men Planned Parenthood	PO Box 1295 Okahandja	-	-
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Ms Diana Shilongo, Coordinator, TACAMOS	P/Bag 5538 Oshakati	065-233068/ 221391	220162

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Ms Lavinia Shikongo, Information and Child Rights Officer, UNICEF	PO Box 1706 Windhoek	061-2046111	2046206
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